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Mental Hygiene in Public Health Nursing

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The mental hygiene movement, although of comparatively recent development, has grown tremendously and in spreading its doctrine is invading many fields where at first its application was unthought of.

Dr. J. W. Bridges in his "Psychology—Normal and Abnormal" defines it as a movement whose object is the promotion and preservation of mental health and is thus a part of the public health movement. Its chief task is the education of the public in the scientific principles and practices which have a bearing upon mental health. It is also the art of handling and correcting various minor problems and maladjustments which may lead to more serious forms of disorders. Its object is not only to prevent mental disease and defect, but also to promote the best type of personality. It, therefore, seeks to encourage scientific investigation into all factors, hereditary as well as environmental, that cause not only mental disease, mental defect and delinquency, but also unhappiness, inefficiency and other undesirable conditions.

His definition seems to outline the scope of the mental hygiene movement wonderfully well and makes the field a very broad one, with plenty of work and openings for every type of worker.

In Canada, at the present time, there is no group of workers more advantageously situated to carry out any mental health programme than the public health nurse. In this group one naturally includes the Victorian Order and other visiting nurses, as well as the industrial nurses. The public health nurse has an entree into more homes than probably any other type of worker and in most cases her presence is welcomed and her advice is listened to. If not always carried out, her suggestions at least cause the parents to think the matter over and realize some of their own shortcomings, which is in itself a good thing. One never knows what may spring from this seed.

The dissemination of sound mental health information is not a field for amateur efforts depending on goodwill and good intentions, but on knowledge. Expert training is required but the field is too large to be usurped by any one professional group. At the present stage it needs co-operative effort on the part of everyone who deals with problems of human behaviour, that is, psychiatrists, psychologists, educators, nurses, social workers, general practitioners, pediatricians, courts, ministers and employers.

One of the first and perhaps the hardest tasks of those carrying the mental hygiene doctrine to the general public, is to overcome those age-long prejudices and superstitions regarding mental disabilities. The very term mental hygiene is apt to bring to their minds a picture of some one suffering from an acute disease or perhaps of a drooling idiot. Perhaps if you are quite honest with yourself you will have to admit that it is not long since this same hoary concept was still firmly rooted in your own mind. Its uprooting is not hurried by the fact that many of the active problems you are constantly called upon to deal with are concerned with these two very situations.

However, you are not ready to do mental health work unless you free yourself from this concept and train yourself to consider it from the angle

(A paper read at the Public Health Nursing Section of the Canadian Public Health Association, annual meeting, June, 1931.)

of prevention as you do general public health work.

Every one of us has our own personal problems and difficulties and we must learn to realise we have to face them fairly and squarely. It is useless to ignore them and to assure ourselves that by shoving them into the background we can solve them. We must sit down and quietly take stock of ourselves and our own every day behaviour. If we can learn to understand something of our own reactions, and where necessary try to allay certain ones, or at least adapt ourselves to circumstances that are unalterable, we will be in a better position to help other people to solve their difficulties. Otherwise these personal handicaps of our own will react on the people we wish to help and will colour any proposed solution we present to them, preventing our maintaining an impartial attitude.

We all know how difficult it is to convince people that a case of mental disorder or defect in their own little circle is not a blot upon the family name and something to be hidden as long as possible—perhaps until the disorder has advanced too far for a complete recovery to be possible or until a tragedy has occurred, or in the case of a defective, until the unfortunate child is too old for satisfactory training. People who will sacrifice everything to secure the best available care for a case of pneumonia will deny the patient this if he shows signs of mental disorder.

In every family of the present generation there is a very evident amount of tug and strain between parents and children, owing to their different attitudes toward life. On one side we have the parents with the traditional, rather than thoughtful attitude—this being especially true of parents from foreign lands, and on the other side there are the children clamouring for changes in home life and yet not being at all sure what they want or why. Every generation has had such problems and ours is no exception. A score of years ago one found parents and children sharing amusements and household tasks as part of the usual routine and the children helping willingly as a matter of course. Nowadays it is quite different and in many homes children help only under protest. The auto, movies and clubs of all sorts, have changed the outlook. Everyone wants to get away from home on various plans of their own. Even the mother, who has always been and still is the most stabilising influence in the house, probably has her outside interests. But despite the fact that we are passing from the days when the family exerted such an exclusive influence on the child's life, there never has been a time when parents and all types of workers could give more intelligent guidance to children.

Unconsciously every public health nurse includes a lot of mental hygiene in her daily routine although she may call it by some other name, such as child or infant welfare, pre-natal instruction, or what not. What a wonderful opportunity a public health nurse has if she has prepared herself to do it consciously in the same thorough way she prepares herself to carry out her public health programme. As a matter of fact, problems of physical and mental health are so closely interwoven it is impossible to deal satisfactorily with one without the other entering in. We will cheerfully and enthusiastically study and work to prepare ourselves to combat physical difficulties and entirely neglect the mental health difficulties. We may flatter ourselves that our public health technique is perfect and yet if we overlook that very potent element—human behaviour—we won't go very far in the majority of cases.

There is no dearth of good practical literature on child training and care, in either book or pamphlet form, easily obtainable so that one cannot claim alibi for ignorance just because there are no lectures or instructions available in the vicinity. In Canadian literature on this subject we have Dr. Baltz' and Mrs.

Bott's book, "Parents and the Preschool Child," which is very practical and readable as well as being inexpensive. There is also the recently published set of pamphlets on "Habit Training" prepared by Mrs. W. T. B. Mitchell for the Canadian Council on Child and Family Welfare at Ottawa, and which may be had on request. These have been found useful for mothers, teachers, and all those interested in child work of different sorts.

It speaks well for the amount of mental hygiene work already done in Canada that there is such an increasing demand on the part of parents for information and help. Parent educators are kept more than busy trying to keep up with requests for instruction from groups ranging from the highly educated, intelligent parent to mothers who must go out daily to work, leaving their children at a day nursery. The questions asked at such group meetings are extremely frank and a purely theoretical solution won't satisfy them. They insist upon knowing, not only the theory, but practical methods of help that is on a workable basis. The questioners may not always agree with the proposed solution but they will turn over the idea in their own minds and discuss it at home, deciding probably in the end to give it a trial, with or without reservations.

The public health nurse who goes in and out of homes on various matters can do much toward stimulating this thirst for knowledge in getting groups organised and helping them to obtain capable leaders for them.

Parents are, of course, the greatest influence in any child's life, especially as they are with him more than anyone else at the beginning when development is most rapid. The mother in all child training and problems is the strategic person and this must ever be kept in mind. Upon the training the mother gives the little child will largely depend the later success or failure of that child in life.

Habits are the acquired methods of behaviour built up by association. They are the tools by which we achieve health, happiness and efficiency. Good habits must be built up from the beginning of life on a basis of the elementary habits. Who, but the nurse visiting in the home, is in a better position to impress and teach the mother the importance of this early training, of these necessary rules — regularity, consistency and persistence in establishing good habits of eating, sleeping and eliminating? Dr. Blatz in "Parents and the Preschool Child" stresses these very strongly.

If all of us doing public health work would concentrate on the effective training of the pre-school child there would be fewer school and adult problems to later perplex us. In working on these latter problems we invariably find the trail leads back to the home where faulty early training, due to ignorance and thoughtlessness, has laid an unsound foundation.

In talking to and teaching mothers there is one point which is apt to be overlooked and often lies back of the failure of the plans made. The nurse must try to size up the parents' mental capacity as well as the environmental possibilities so that the formulated plan lies within the range of success. A plan should be presented that will not be too complicated for the mother to grasp the significance of and which she may carry out with a feeling of compensation. If she obtains a feeling of success, she is repaid for all her struggles and will be spurred on to further effort. Often we are inclined to use language, which may be of quite familiar everyday use to us in our profession, but the meaning of which the mother may only half or vaguely comprehend. Ten chances to one she may be the sort that privately visualizes germs and vitamines as little green bugs cheerfully leaping around on lettuce or cabbage leaves.

A very fruitful field, and one that is assuming more importance as time goes on, in mental health education, is the work among pregnant mothers.

Every public health nurse has any number of women in this condition under her supervision, but how often does she concern herself with what is going on in their minds? Naturally she pays a great deal of attention as to whether the physician finds the patient's physical condition satisfactory and whether she is carrying out, to the best of her ability and opportunities, his instructions as to diet, rest and recreation. Possibly the nurse advises the woman about the arrangements and nursing care of herself during confinement, the provision for care of the household during this period, but does she concern herself, or realise very often, the mental stress the woman is undergoing?

Although pregnancy is a normal experience in a woman's life, yet her outlook will often be as exaggerated as that of a sick person. Her pains and aches are enlarged, mole hills temporarily become mountains, specially towards the end of the nine months' period. Perhaps she does not feel equal to going about much among her friends and her thoughts turn in upon herself. It is during the pregnancy that the nurse has a chance to do a worthwhile piece of mental hygiene work. These are the months when the nurse can get the prospective mother planning for the future training of the baby. How is she to fit it into the household? How she should institute the satisfactory habits that are so vitally necessary for the baby's future health, happiness and efficiency, as well as her own satisfaction and peace. Every mother naturally wants a healthy baby, but she doesn't often realise how much those first months and early years count in the child's whole life. Many times in the rush and pressure of work this angle is not sufficiently stressed, but as time goes on the importance of habit training is beginning to percolate into every mother's mind.

It is too late to start talking about it after the confinement, just as it is too late then to prepare the other children, specially the youngest who is supplanted by the new arrival. This little tot, who suddenly, without any warning, finds himself ousted from the centre of the stage and the chief claim on mother's attention, often undergoes a severe shock. Think of how often some one thoughtlessly in a joking way says to the child some such thing as this, "Now your nose will be out of joint, mother has a new baby." Immediately all his props are knocked out from under him and the seeds of jealousy and hatred are planted in a plastic mind. It is so easy to plant such seeds, but difficult to get rid of them. How much better to have prepared the child for the new baby so its arrival will be looked forward to and the desire to help care for it fostered.

Where a public health nurse holds a meeting or club for pregnant mothers she should plan to give mental hygiene a definite place in her programme. Much effective teaching has been done in such clubs in the United States and we should not fall behind in Canada.

Another field into which the nurse can carry her mental hygiene education programme is her work among tuberculosis patients. We all know that peace of mind is a great factor in any sick person's recovery and this is especially true of tubercular cases. They usually seem very hopeful of recovery but back of it there are frequently fears and worries that come to light under a little careful probing. There is nothing more helpful in clearing up these fears and worries than bringing them out in the sunshine and fresh air as it were, putting them into words and talking them out with an understanding person.

When it comes to school children, every public health nurse has innumerable problems of every imaginable sort with every possible type of child. It would not be possible, in a paper such as this, to do more than briefly touch on a few ways in which she may do useful work. A nurse is, of course, no more qualified to diag-

nose and prescribe treatment in cases of mental or emotional disturbances or defect, than she is in cases of physical disease and yet in the former, as in the latter case, she may institute certain perfectly obvious emergency treatments until help is available. To the psychiatrist her help is as important as it is to the physician. He depends on her to bring him a true picture of the child's difficulties, his home and environmental background, a history of his development, his behaviour in school and out, his progress, recreational activities or lack of them, and the doctor's latest physical findings —not forgetting to have the information include the correct date of birth. If a psychometric test is to be given the examiner must have this in order to work out his rating. This may seem to be a small unimportant point but if you were attached to a division of mental hygiene which tests several thousand children each year it would loom up as quite a burning question and not a complex.

The information for the psychiatrist should be arranged systematically and as briefly as possible. The reasons for bringing the child for examination should be stated clearly at the beginning and then the history given according to the outline in vogue at the clinic. All clinics have a definite history outline to be used in preparing a history so that points may be placed in their proper order and not in a long, rambling story which may, or may not, contain all the essential information.

Histories are not always easy to obtain, but they are very necessary if any real study is to be made and a plan formulated. Incidentally one learns a great deal about people, their ideas and attitudes about life in general while getting histories, as well as becoming adept at weighing and sifting the material gathered so that details which at first glance might be overlooked or thought irrelevant, and yet contain the key to the situation, may not be omitted.

Nurses and social workers usually say it takes a long time to get the necessary material for a history because you cannot sit down with the clinic outline before you on a table in the home and ask one question after another, expecting to get a really true or valuable history. The questions asked in such cases merely suggest to the mother the answer that will make the best showing. Rather, with the outline in the mind's eye, much real information has to be elicited in the course of a general conversation skillfully directed by the questioner and by quietly observing the mother's method of handling any other children in the home at the time and by their attitude toward her. Of course when one is obtaining names, dates, diseases and such like, notes have to be made and other bits of information may be jotted down at this time.

When it comes to getting the report from the school teacher, the psychiatrist will expect definite information, especially if it is the school which requests the examination. Progress or lack of it, subjects failed in, grades repeated, attendance, behaviour in school towards work, teacher, and other pupils, and so on. Is his physical condition keeping the child back, does his teacher ridicule him or scold him before the class, or does she teach too much and not make her pupils do enough learning on their own part?

If stealing is the problem—and it is a very common one—one must find out what form this takes. Is a little child branded as a thief when he picks up some bright or attractive object from another's desk because he has never been taught at home the difference between thine and mine, and desires these pretty things he cannot get otherwise? Perhaps he deliberately steals money in order to spend it to buy the good-will or admiration of others or even to buy food he craves and lacks at home. Every child should be given or allowed to earn a regular weekly allowance, no matter how small the amount, and this he should be per-

mitted to spend in his own way. He should not have to put it all in his bank or on the Sunday collection plate. The nurse can often help in such cases.

Gang stealing is not an unusual difficulty, specially in the larger centres. Sometimes the gangs are quite well organised, perhaps after ideas absorbed from the trashy literature overflowing our bookstalls and selling so widely, or from the undesirable sensational type of "movies" frequently shown. The leader may not do so much of the actual stealing himself, but directs his gang, often using the duller members, who are short on ideas of their own. One quite common example of this in big cities is the game carried on by these gangs in visiting a "5 & 10c" store. Each member sees how much he can "lift"—the spoils going to the winner, that is, the one who can annex the greatest number of articles in the raid. He has the privilege of dividing or disposing of the spoils as he decides. This game goes on until some one makes a slip and lands in a juvenile court, where the story is uncovered and the gang broken up. If these gangs can become interested instead, in some form of useful or helpful activity, a lot of surplus energy may be turned into channels of benefit to the whole community, as well as the gang getting a stimulus and satisfaction out of it.

Lying is another common problem, often though not always linked up with stealing, which must be traced to its beginnings. However, it is too large a field for this discussion.

The children who cause trouble of any sort, and those who cannot keep up with the others in school, are the ones most commonly brought to a clinic for help and advice, but the type of child whose behaviour to the psychiatrist presents a far graver problem may often be overlooked for the very reason that he never causes any active disturbance until he later on develops an active psychosis. This is the shut-in, seclusive, over-sensitive child who doesn't play with other children, but sits around day dreaming, whose feelings are always being hurt, the child who shrinks into the background and doesn't take any interest in the usual child activities. Children of this sort are always well worth studying and helping.

One might go on for a long time enumerating different problems in children, all fascinating, and often distracting and perplexing enough to challenge the worker's ingenuity.

In the majority of cases the trail leads back to the home, which brings us back to the same old point. If you want to do good mental health work, the mother is the strategic person to work with and in her co-operation lies the key to success.

Child guidance clinics are steadily increasing in number and will continue to do so, as fast as the public health nurse, who is so often the only active trained worker in the area, can teach the parents and schools the value of them. The travelling psychiatric clinics, staffed from provincial mental hospitals, beginning to work out in districts where no service to the present has been available, are already proving a great success. The nurse must make her families aware of the possibilities of clinics as centres where advice may be sought early in the game before some serious difficulty has arisen. She must teach them to recognise the danger signals and to look for the cause. The child should not be altogether to blame, but parents made to realise their own failures and shortcomings in training and example and that they must try to rectify these in order to help the children. Everyone of us is quite willing and anxious to accept credit for successes, but not so keen on shouldering blame for failures.

Until one is actively engaged in mental hygiene work one is rarely fully alive to the good that wholesome physical activities play in a child's life. It is surprising how many children have to be taught to play. All children need to learn to play games, not with the idea of al-

ways winning, but of learning to give and take cheerfully and of putting their best efforts into the game. We all know no football game is ever won or lost till the last whistle blows.

If adolescents learn to play the game in their earlier years, they are not so prone to hang round on corners or to gather in little groups with nothing better to do than gossip or exchange unsavory misinformation about sex. The Boy Scouts and Girl Guides troops and their kindred organisations have been a great boon and eye-opener to many boys and girls, both from the physical and moral point of view.

With the recognition by the educational authorities, all over the country, of the need and advantages to be derived from the provision of special training for the mentally retarded, many a problem has been solved and the teacher's burden lessened. The teacher's preparatory training, like that of a nurse's, however, is still sadly lacking in definite instruction about human behaviour.

In Toronto we have found the special training classes the greatest help. We have a steadily increasing number of such classes from which, at the age of thirteen, the pupils are sent on to three vocational schools for three years' training in whatever trades they prove to be suited for. In these junior classes the academic work must be stressed but of course the curriculum has to be continually adapted to the need and speed of the pupils. Some manual or handwork is given but loses most of its great value if not very definitely linked up with the academic work. In the vocational schools this linking up of academic and vocational work is equally important, and it is surprising the diversity that may be developed along both lines. In both classes and schools much attention must be devoted to developing good health and moral standards, and in a great part this has to be done individually rather than in the group work possible with the average child.

One great feature in the success and happiness to be achieved in such classes and school is the prevention of stigmatizing them, calling them the dumbell classes or other cruel names. The pupils should not be made to feel they are different, but rather privileged by having special training. These classes are usually the busiest and happiest spots in a school.

When some similar sort of training can be thought out and put into practice for that very large and troublesome group known, for want of a satisfactory name, as the non-academic or dull normal group, we will have travelled quite a distance along the road to solving many truancy and juvenile court problems.

In all educational schemes the nurse has a very definite place. She is the all-important link between home and school. Her aid, diplomacy and knowledge is a great factor in recognising wrinkles and ironing them out before a permanent crease is made, whether the main source of trouble lies in misunderstanding and friction in school or home, or between these two great agencies for good or evil in the child's life.

If a nurse does not honestly like children and isn't willing to be patient in trying to understand them, she should not enter the public health field as it is a foregone conclusion she will not make a success of mental health work. In no branch of the work does she need so much to have infinite patience, resourcefulness and insight, along with a sense of humour and a refusal to become discouraged despite the realisation that there are plenty of conditions that will not be changed, but may be modified, in her day and generation. These qualities along with a love and understanding of little children are part of the necessary everyday equipment of anyone who desires to prepare herself for mental hygiene work. Let me close with the assurance that it is a work that holds a never-ending fascination, a great satisfaction and a challenge for everyone who enters its lists.

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Editorials

THE NATIONAL ORGANISATION

Elsewhere in this issue of the *Journal* there is illustrated in chart form the effect numerically on membership in the Canadian Nurses Association following the decision made at the Biennial Meeting in 1930 to abolish dual membership in the national organisation.

It was recognised the doing away with *that* plan meant renewed activity on the part of each Provincial Association of Registered Nurses to increase its membership in order that every registered nurse should maintain affiliation with the Canadian Nurses Association and the International Council of Nurses.

Numbers alone do not demonstrate the professional solidarity among nurses in Canada. However, there must be unanimous opinion that until every qualified nurse becomes registered and continues to be a member of a provincial association, the Canadian Nurses Association cannot be regarded as Canada's phalanx for the nursing profession as those who have given so generously and voluntarily toward leadership in the national organisation anticipated.

On numerous occasions we have been challenged to personal responsibility in contributing our best to the exigencies of our professional development and progress. Cannot the individual member in the provincial associations resolve now to accept her responsibility to convince one or more of those who have carelessly overlooked becoming registered or who have failed to maintain membership in a provincial association to establish a National or International affiliation before the end of this year? The national organisation needs each nurse and the international body also needs each one of us. What shall be our response before December 31st, 1931?

BIENNIAL MEETING, 1932

The months have a way in passing so rapidly one after another that one is rather surprised to note that the members of the Canadian Nurses Association must now direct their thoughts and interest toward the next general meeting of the National Organisation. Accepting the invitation of the New Brunswick Registered Nurses Association, that meeting will be held in the Admiral Beatty Hotel, Saint John, New Brunswick, from June 21st to the 26th, 1932.

Miss Florence Emory, President C.N.A., is convener of the Programme Committee. The programme for 1932 will concentrate on the Report of the Survey, which it is expected shall have been carefully studied by every registered nurse in Canada before the general meeting of 1932 takes place.

Miss Margaret Murdoch, Superintendent of Nurses, Saint John General Hospital, is convener of the Arrangements Committee. Miss Murdoch has chosen her associates from members of the hostess organisation and shall report preliminary arrangements to the Canadian Nurses Association Executive Committee towards the end of September.

At the request of the Executive Committee, Canadian Nurses Association, Miss H. S. Dykeman, of Saint John, has consented to act as convener of a special committee appointed to arrange for post-convention tours in the Maritimes.

No further information relative to the general meeting of 1932 is available for release at present. However, the *Journal* shall report promptly the development of all plans. It is anticipated there shall be a record attendance owing to the importance of the coming meeting with the Survey Report discussions, as well as many wishing to avail themselves of a trip

through a most attractive part of the Dominion and to meet especially the members of the Canadian Nurses Association resident in New Brunswick.

The Canadian Nurses Association has met once only in the Maritimes, then in 1914 in Halifax, Nova Scotia, so that the majority of those attending the 1932 meeting shall be visiting the eastern provinces for the first time.

The nurses of New Brunswick are preparing to receive a record breaking attendance. Let us not disappoint them.

INTERNATIONAL COUNCIL OF NURSES

A meeting of the Board of Directors of the International Council of Nurses was held in Geneva, June 29th to July 1st, 1931. The Board of Directors consists of (*a*) the Honorary Presidents in office in 1925, and (*b*) the elected officers (5), and (*c*) the President of each National Association of Nurses which is an active member of the International Council of Nurses. There are 23 National Associations affiliated with the Council, which, on January 1st, 1931, had a membership of about 160,000.

Officers present were: President, Mlle. Chaptal (France); treasurer, Miss E. M. Musson (England), and secretary, Miss C. Reimann; also the following members of the Board attended: Mrs. Bedford Fenwick (Great Britain); Miss Elnora E. Thomson (United States); Miss Charlotte Munck (Denmark); Sister Bergliot Larsson (Norway); Mademoiselle Parmentier (Belgium); Miss Alice Reeves (Irish Free State); Miss Anna Nordstrom (Finland); Miss Madge E. Abram (India); Miss B. G. Alexander (South Africa); Generaloberin Lubben (Germany).

It was decided that the Congress of 1933 should be held from July 9th to July 14th. The first three days' sessions shall be held in Paris; Thursday spent in travel to Brussels, sight-seeing en route, with sessions held in Brussels on Friday and Saturday. It is proposed that meetings of the Board of Directors and the Grand Council shall be held during the week previous to the opening of the Congress.

The secretary's report showed the increase and development of activities at headquarters and suggested an adjustment should be made in the staff in order that progress and expansion could be more satisfactorily accomplished. A full time assistant editor for *The International Nursing Review* is to be appointed.

An interesting report presented by Mrs. Bedford Fenwick as chairman of the Florence Nightingale Memorial Committee was adopted. Recommendations made in this report were:

(*a*) That the Florence Nightingale Memorial Committee be extended by the inclusion of the Presidents of all federated National Associations;

(*b*) That when it has formulated more concrete suggestions, influential persons in each country shall be included in the Organising Committee, and

(*c*) The Board suggest that the Foundation should be in London, that it should be of an international character and a living memorial—not a museum; members of the Board of Directors assembled in Geneva favoured an endowed Foundation for post-graduate nursing education.

Appointments and vacancies on Standing Committees which occurred since the Congress of 1929 were made as follows: Chairman, Private Duty Nursing, Miss Isabel Macdonald (England); Programme, Congress, 1933, Miss Elnora Thomson (United States); Revision of Constitution and By-laws, Miss Margaret Breay (England); Ethical Standards, Miss Mary Roberts (United States).

SEPTEMBER MEETINGS

The month of September is outstanding in that two most interesting annual conventions from the United States are being held in Canada. The first is the Sixtieth Annual Meeting of the American Public Health Association, which meets in Montreal from September 14th-17th.

Nurses in Canada will be especially attracted to the arrangements made by the Public Health Nursing Section of the Association, which include a luncheon meeting, one individual session and joint sessions with the Child Hygiene and Public Health Education Sections.

At the close of this annual gathering there will be a trip by steamer to Quebec City and up the Saguenay River. Information relative to this trip may be obtained on request being sent to the American Public Health Association, 450 Seventh Avenue, New York City.

Editorial comment was published in the July number of the *Journal* relative to the annual convention of the American Hospital Association, which meets in Toronto during the week of September 28th to October 2nd. Fortunate indeed are the nurses who have delayed their vacation until September if their plans permit them to be in Montreal and Toronto for one or both of these large gatherings.

Miss Anna D. Wolf will preside at meetings of the Nurses' Section. Miss Wolf was recently appointed Director of the School of Nursing and Director of the Nursing Service in the New York-Cornell Medical Centre now under construction in New York City.

The Woman's Hospital Aid Section will be presided over by Mrs. A. W. Rhynas, of Burlington, Ontario. Headquarters for the American Hospital Association will be in the Royal York Hotel and reservation for accommodation should be made at once.

THE PERMANENT EDUCATION FUND

Registered Nurses Association of Ontario

At the fifth annual meeting of the Registered Nurses Association of Ontario held in Toronto, April, 1930, it was decided by unanimous consent, at a general meeting of the Association, to establish a fund for nurse education, this fund to be known as The Permanent Education Fund of the Registered Nurses Association of Ontario.

The purpose in mind in the creation of this fund was: first, to provide funds to finance, if necessary, the preparation of especially qualified persons for educational or administrative work, the result of which would benefit the nursing profession, as a whole, in Ontario; second, to provide a loan fund to be used to aid and assist individual nurses, members of the Association, to secure special post-graduate education and experience.

The definite plan of the administration of the fund has not been considered; when it has been definitely established, according to the plan decided upon by the Association, then the matter of dispensation of the funds will be given consideration at a general meeting of the Association.

The plan adopted to raise the money is as follows: Each district is expected to contribute at the rate of one dollar per member per year for five years. Each district may adopt its own plan of securing the funds. At the present time some districts are endeavouring to raise the money by taxation of each member within the district, while others are adopting the group effort plan.

It is hoped that the creation and fulfilment of this fund by the Registered Nurses Association may lead to the stimulating of interest in nurse education, and perhaps financial assistance, of the citizens of Ontario.

*Evolution of Nursing in the Last Forty Years**

By NETTIE B. LITTLE

Someone has said that the person who has gone through hardships treads the earth more proudly. In retrospect, the last forty years have been a period of progress for the nursing profession, but every inch of that progress has been contested. Only by patience and wisdom, and matching of wits against political and other adverse elements, has our present status been attained and maintained. Opposed at every turn, defeated again and again, without power, without resources, by sheer weight of faith in themselves, nurses are winning freedom to direct their own work, whose needs they know best, and thus to shape their own destinies. Hence we, too, walk the earth more proudly.

It was Miss Nightingale who first set our feet upon a firm foundation. She placed the art of nursing on the plane of a profession and transferred it from the category of domestic to that of medicine. She also took it out of the place where it had been placed before her time by the religious orders, who regarded their nursing chiefly as a means of self-abnegation and humiliation. She recognised that the skilled services of the trained nurse should be an honourable means of livelihood, and insisted on public recognition of that fact.

Although the status of the nurse had been changed, her position was precarious, and the young profession felt the need of organisation for mutual protection, for strength to accomplish projects for betterment and for moulding of ideals. Leaders were not lacking. Pioneer work always attracts its own leaders, and to Mrs. Bedford Fenwick it was given to lead, not only the British nurses, but the nurses of the whole world, in their struggle for legal status. There was the strongest objection to any form of legal status for nurses founded on the principle of self-government, and it was only the courage and pluck of the British pioneer nurses who persistently fought any proposals of the Government for the nursing profession which did not provide for the adequate representation of the nurses themselves which secured for them a law that has stood the test of time.

The struggle in England lasted for thirty years. Never has a woman's organisation met with such determined opposition in the attempt to subjugate it, and all came to realise that the nurses' question was simply the woman question. After many attempts at organisation with others than of their own sex, the Matrons' Council was organised, which proved to be the most invigorating power in English nursing affairs. When the International Council of Women met in London, the Matrons' Council secured the inclusion of nursing in the programme, which gave the opportunity for an international gathering of nurses. Mrs. Fenwick took advantage of the opportunity to propose an international organisation for nurses, and out of this proposal of such magnitude and scope evolved the International Council of Nurses in 1899. In the meantime the struggle for registration continued, and finally in 1919 the Registration Bill was passed. In no other country have nurses had to fight so hard and so long for legal recognition. Others satisfied with a lesser good are now finding how irrevocable is a law once passed.

Thirty countries now have registration, and the type of registration in force in each country depends upon national and racial characteristics, the general position of women in the country, the stage to which nursing has advanced and the degree to which nurses are recognised. But whatever the type of registration, raised standards have inevitably followed.

If the task of legislation has been difficult, that of education has been

(*Paper written for the course in History of Nursing by Miss Nettie B. Little, student in the School for Graduate Nurses, McGill University, Montreal, 1930-31.)

no less. The school for nurses is unique in education. Similar conditions do not exist in any other educational institutions. It is apprenticeship pure and simple, picked up by the hospitals at a time when trades and other professions were endeavouring to throw it out. The primary interest of the master craftsman is production, and the education of his apprentice a secondary interest, which must, in case of conflict, give way to the larger interest. Similarly, the director of the school of nursing, being also director of the nursing service, must in the very nature of things give precedence to the care of the sick.

The public do not pay for the nurse's education as they do for that of other professions. The student nurse pays with her services a much larger fee than any college demands, and sometimes she pays with blood! The whole educational system is built up within or after the full day's labour in caring for the sick, when body and spirit are crying out for rest. Every inch in the progress of the nurse's education has been contested, every additional hour and subject in the curriculum questioned and opposed, everything in fact that would illumine the nurse's pathway and lift her to a fuller comprehension of her task. Obviously, the male head of the hospital and his board, willingly or unwillingly, knowingly or unknowingly, are blocking our path to progress.

The education of the nurse is in a state of transition, and at present there is little uniformity. All kinds of experiments are being tried with more or less success. As far back as 1893, The Royal Infirmary at Glasgow established a primary course of three months when there would be learning under school conditions. In 1901 in America, a similar course was established in Johns Hopkins Hospital. Professional schools scorn our low admission standards and our haphazard hit and miss grading. Nevertheless, the present trend is toward the professional school. The entrance requirements are becoming more exacting, one to four years' high school being required, and university desired, with a constant broadening of the curriculum. The professional education is given from three to five years, under a standard curriculum systematically and carefully graded and educationally sound, and more and more the demand is for trained teachers. Some of the special courses are given in central schools or at the university, and clinical work is under teaching supervision. Post-graduate courses are offered by several universities, some leading to a degree. Scholarships are becoming conspicuously numerous. The introduction in 1914 of a curriculum for schools of nursing has helped to strengthen materially teaching in every subject, and the Goldmark Report and other studies in nursing education have clarified many problems. Our best schools have whole teaching units and their own budgets, fully trained staffs of teachers, laboratories and libraries. These schools require their students to pay a fee for tuition.

It is strange that hospitals have persisted so long in retaining the twelve-hour day and seven-day week when an eight-hour, six-day week has generally been accepted as the maximum for a normal healthy life, and has in most departments of the world's work been enforced by law. However, this too is changing, and no doubt the eight-hour day will soon become the standard schedule of duty hours, for it is now recognised that a student after a twelve-hour day is quite incapable of further effort, mental or physical. Shorter hours of work, together with better housing and living conditions, are factors in the solving of the educational problem. Under the Registration Acts, schools are inspected and minimum curricula set.

Charles Booth says that wherever a nurse enters, the standard of life is raised. It speaks volumes for the educative power of the school of nursing that from the meagrely or incorrectly educated material there are finally sent forth so many capable, skillful women worthy of this tribute.

A Call for Readjustment

By E. MURIEL McKEE, Brantford, Ont.

Another year has passed. Again we convene as the Registered Nurses Association of Ontario to consider those things we have accomplished and those things we have failed to accomplish. On such an occasion as this we should endeavour also to catch a glimpse of the future possibilities for the development of our profession; first, through the minds of the many nurses gathered here, representing as we do every phase of nursing; second, by the consideration of our work in relation to the needs of the people and in relation to the work being conducted by other groups; in fact, in relation to everything touching upon the care of the sick and the preservation of health. As our vision so will be our progress.

The Association cannot report any outstanding accomplishment during the past year, yet several progressive steps are to be noted: (1) we have established a Permanent Education Fund, (2) we have joined forces with the Red Cross in the enrolment of registered nurses for service in times of war or disaster. The committee appointed to present the nursing profession to high school students has its work well under way. The function of this committee is not to endeavour to secure more applicants for the nursing profession but to secure applicants better fitted to enter the profession. The committee appointed to consider the problem in connection with non-Ontario registered nurses practising in the province has now a full report to present. What action is to be taken with the facts revealed remains for the members of this Association to decide. The Legislative Committee has, at your request, carefully studied the constitution and by-laws of the Association and has suggested certain revisions; each member of the Association has had an opportunity to consider the suggested changes.

The activities of the three sections —Nursing Education, Private Duty, and Public Health—will be reported at the section meetings. However, a word of commendation should be expressed on this occasion to all sections for the splendid refresher courses held during the year.

Analyses of Facts

It is easier to cry "Onward" than to say "Whither." We are awaiting the guidance we hope to receive from the report and recommendations in connection with the Survey of Nursing Education and Nursing Service in Canada, which is being conducted jointly by the Canadian Medical Association and the Canadian Nurses Association. The time of waiting, however, has not been in vain. Because we have been called upon to analyse our own fields of work, in order to furnish facts as requested in connection with the Survey, we have become acutely conscious of the need for readjustment of our method of supplying nursing service. The present situation in connection with unemployment among nurses is demanding our careful consideration. It is doubtful whether, when we read the report of the Survey, we will be greatly enlightened in so far as our weaknesses are concerned: what we hope to get from the report are sound, feasible recommendations, based upon knowledge of facts, which will enable us to bring our nursing service into line with present-day needs. What are the glaring faults in our present-day system which not only the nurses but the lay-people and the medical profession are recognising? Probably

(President's address at the annual meeting of Registered Nurses Association of Ontario, April, 1931.)

the most glaring are these facts: that annually we are training more nurses than are required to provide nursing service for our province and that a large proportion of the nurses graduating each year are unqualified to enter many of the fields of service. What is the cause of the existing condition? It is the custom to use schools of nursing to supply the nursing service for patients in hospital irrespective of the need, in the community, for these nurses when they graduate. In order to supply this service we are accepting into our schools students with insufficient academic education, or lacking in other qualifications necessary to fit them for nursing service; in other words, each year we are graduating students whose usefulness is limited and whose progress is restricted.

How many of the students graduating each year are qualified to enroll in our universities for post-graduate study or to accept appointments with the visiting nursing organisations or on hospital or nursing school staffs? In May, 1930, 586 graduate nurses wrote the provincial registration examination; 279 of these nurses had less than three full years of high school and only 98 nurses held pass matriculation certificates. Why do public health and visiting nursing organisations and hospitals require their appointees to possess a sound academic education as well as the training of a nurse? In these fields of service the nurse must be a teacher: the school nurse teaches the children and their parents, the industrial nurse teaches the employees and their families, the visiting nurse and the hospital staff nurse are constantly teaching patients and their families as well as nurses and medical students.

How does the supply of nurses relate to the demand in the various branches of our work? We are led to believe that the demand for nurses qualified for public health and visiting nursing service and for appointment to hospitals and schools of nursing staffs is not equal to the supply within the province; whereas the supply of nurses engaged in special or private duty nursing far exceeds the demand. The increasing problem of unemployment in this group would seem to indicate that our presumption is correct.

There is need for readjustment as to our method of supplying special or private duty nursing. For economic reasons we must devise a plan whereby we can supply special service to the sick according to their individual requirements. The very large group of nurses engaged in this type of work must signify emphatically their willingness to co-operate with hospital administrators and visiting nursing organisations in their attempt to work out a satisfactory arrangement. Group nursing will be developed, if not with our aid, then without it. In the readjustment, in this branch of nursing, it is obvious that two things will have to be considered. One of these considerations is that some nurses will have to seek new fields of endeavour. Our universities offer courses in preparation for public health work or for teaching or administration in schools of nursing, and at the present time every consideration is shown to the nurse who, by reason of valuable experience, may be deemed to have qualifications which can be considered as equivalent to academic work. In hospitals there are several posts now usually filled by lay workers for which a nurse is especially qualified. She may if she has administrative ability and a business education become a hospital administrator, a hospital secretary or an admittance officer; with a very short period of special training a nurse may qualify for positions such as a record librarian, an x-ray or laboratory technician. The other important consideration is that the group who from choice engage in bedside nursing should be organised so as to provide for the selection of the nurses with special qualifications for this work, and for some supervision of their work just as is now

the case in public health and hospital fields. At the present time nurses not successful in obtaining appointments in other fields of nursing, naturally seek employment as private duty nurses. Who has not heard it said, "Well, of course, I can always go back to private duty nursing" Some of our finest nurses are engaged in this important work and I desire to pay tribute to them.

The Future

The vision I get of the future, and my vision may be wrong, is this: there will be wider use of the visiting nursing organisations by all people, rich, middle class and poor, possibly to the extent of supplying all nursing service in our homes. A greater effort will be put forth to teach lay women so as to fit them to carry out, in their homes, simple instructions given by the physician or by the nurse. I refer to home nursing courses, mothercraft and pre-natal instruction, and so on. Every hospital will become the health centre of the community it serves, conducting educational and diagnostic clinics. County health units will be established to serve the districts not having hospital service. All patients requiring constant nursing will be hospitalised; the trained visiting housekeeper will help to make this possible.

Hospitals will use graduate nursing service for general duty to supplement the student nurse staff and to supply, as an economic measure for the patients, all special nursing required. Many schools of nursing will be discontinued, and those maintained will offer nursing education and training to qualified women, according to the facilities and experience available in the hospital and not according to the nursing service required to care for the patients.

It is not necessary for those nurses now conducting schools of nursing to stand by and wait for the Report of the Survey to be published. That some readjustment will have to be made is inevitable, but before this can be attempted there is much "spade work" to be done in the matter of supplying knowledge concerning our problems to those who will be instrumental in aiding us to find a solution for them. I am thinking of hospital boards, the citizens of the community, and the high school students.

Changes will have to be made very gradually as it is obvious that financial difficulties in connection with hospital administration will arise. It is a fairly well established fact that small hospitals can be administered just as economically with a graduate nurse staff as with a nursing service supplied by student nurses, especially if the school of nursing meets the requirements for "approval." In large hospitals, where the facilities and services offered for the training of nurses justifies the conduct of a school, it will be difficult to reduce the number of students because of the fact that the same educational facilities and personnel will, to a great degree, be required for a limited number of students as are required for the large groups who now provide almost the entire nursing service. However, in every centre, large or small, where a school of nursing is conducted the number of students enrolled should have a definite relation to the demand for nursing service in the community. In the future when hospital bed capacity is increased the additional nursing service required should not be met by increasing the enrolment in the schools of nursing but by additional graduate nursing service.

Private duty nurses should heartily support superintendents of schools of nursing in their effort to select better qualified students and to limit the enrolment in nursing schools.

So much for the problems to be dealt with. Now, when and where shall we deal with them? Can the few so-called leaders in our profession study the problems for us all and give us the answer? Can each group—nursing education, private duty, and public

health—consider its own problems as an independent group and make satisfactory readjustments? Like Miss Ethel Johns, I believe we must find common ground upon which to meet and discuss our problems. The problems of the sections are so interrelated as to require common consideration; like building up a jig-saw puzzle, we must work away with the awry pieces until we find the section into which each piece fits to make a complete picture. Where shall we find this common ground? If we but consider for a moment the aims and objects of the Association responsible for our being assembled at this moment, we must realise that here is the common ground. *To advance the educational standards of nursing; to maintain the honour and status of the nursing profession and to render service in the interest of the people*: surely these aims are common to every nurse in every field of work.

At the moment, is our Association representative of the nursing profession in Ontario? The chart before us was prepared by the President of the Canadian Nurses Association and sent to our Association as a challenge, in an appeal for our support, by membership in our National Nursing Organisation. Fifteen per cent. of the registered nurses in Ontario are endeavouring to conduct the nursing affairs, while the remaining eighty-five per cent. participate equally with us in benefits derived from our efforts. We must assume from this picture that, to the great majority of nurses in Ontario, there is no professional obligation associated with membership in the Registered Nurses Association. It merely means to them the payment of an annual fee to swell the treasury of the Association; we have failed to impress them with the all-important fact that the Association is or should be the common meeting place for nurses in every branch of work, and that each nurse should contribute of her time and talent so that our aims may be realised to the fullest possible extent for the good of all.

Protecting the Mentally Unstable

By F. H. C. BAUGH, B.A., M.D., C.M., Homewood Sanitarium, Guelph, Ont.

There are a great many people who have a constitutional predisposition to mental disease. Many of these, if they remain in a simple environment where they can get a fairly comfortable living without too much worry and stress, can go through life without showing any marked mental symptoms. That is to say, they can adjust themselves to such an environment because they are sufficiently capable mentally of facing the realities of this life, and of solving fairly satisfactorily such problems as may arise. Failure to adjust themselves properly very often results in temporary or permanent mental derangement.

These mental disturbances vary a great deal. Some are very mild and some are very severe, but everyone of them should be thoroughly investigated. The individual may just become excited and elated, cause a good deal of annoyance but do very little real harm. Some may become indifferent, seclusive, irritable, refuse to work and just lie around. Others become agitated, depressed and confused. Far too often we are shocked by tragedy into remembrance of what may occur when one of these constitutionally inferior individuals faces defeat in an environment that is too complex for him.

This mental upset may be precipitated in hundreds of different ways. By way of illustration, we will say that a young man of this type inherits the farm on which he was born. He has always been quite happy there and makes a fair living. He marries a city girl who soon tires of farm life. To keep peace he sells the farm and moves to the city.

Here everything that he does is wrong. The house and car that he buys and the style in which he lives are all beyond his means. He is not trained for any position that will

command a salary to support all of this. He tries various agencies, salesmanship, etc., and is outdone by trained men. He falls a prey to sharpers. Gradually he loses ground financially—he mortgages the house, borrows on his insurance and dabbles in the market in an effort to pull up. At the end of four or five years, he is hopelessly in debt. He longs for his farm but there is no way back. He is slaving away at a job that will not properly feed and clothe his wife and three or four children. The wife is irritable and unsympathetic. She cannot understand why he is a failure and taunts him by saying that the fellow she passed up to marry him provides much better for his wife and family. All day he works, worries and broods, and each day the situation becomes more desperate. He cannot get any more credit at the grocery, creditors hound and threaten. His employer notices his depression and believes it to be indifference or laziness. He speaks sharply to him about it. To the already harassed, unstable individual this means that the job is as good as lost. Sleepless nights follow, and as he lies there in silent, indescribable agony, he visualizes his children ragged, cold and starving with no future but poverty and immorality. Negativism prevents him from seeking charity. He is overwhelmed by a feeling of inadequacy. The more he worries, the more exhausted, confused, panicky and irrational he becomes.

He is now about at the breaking point and some additional shock, such as losing his job, being sued, or ordered to leave the home, will completely derange him. At this stage he may hear voices (auditory hallucinations) telling him what to do. Anyhow the solution suddenly comes to him, but alas! It is born in a sick mind—the only way out. The wife and children must die. If possible he will kill them while they sleep, but he will kill them anyhow and then kill himself. Too often he is the one who survives.

What becomes of him?

He may be mentally deranged during the remainder of his life. Very often, however, from six months to a year in a mental hospital restores him to *his* normal.

At present we do *not* pay enough attention to these mentally sick and harassed individuals. There has never yet been a tragedy but somebody knew about the condition of the sick individual. Somebody, had they known what serious consequences might ensue, could have taken the sick man and placed him in safety. Let a child with scarlet fever mingle with neighbours' children and see what action is taken. Follow the next drunk man you meet on one of our busy streets and see how far he goes. On the other hand, a man can get so depressed that he weeps, says life isn't worth while, that he is a burden to the family and would be better dead. Even then he is not taken seriously. He has very often to make a definite attempt at suicide before his own relatives get really alarmed. Too often it is stated that those who talk of suicide do not take their lives. This is a dangerous attitude. It is all the more dangerous because there is a grain of truth in it. Neurasthenics sometimes threaten suicide to elicit sympathy and attention. The individual should be closely examined by a competent psychiatrist.

It is to be hoped that the day will come when children will be checked up closely. Then it will be as essential for teachers and parents to report mental disturbances as it is to report scarlet fever or small-pox now. A record will be kept of those exhibiting mental symptoms and they will be examined from time to time. If their conduct is in conflict with the laws of society they can be properly cared for before they commit crime.

In the meantime, however, physicians, nurses, social service workers, teachers, clergymen, Salvation Army leaders and even policemen, can teach *that every case of depression should be regarded as a probable suicide, homicide, or both.*

The Four F's

By ETHEL C. PIPES, Dietitian-in-Charge, Vancouver General Hospital, Vancouver, B.C.

While the sister sciences, dietetics and nutrition, are making tremendous contributions to the happiness and well-being of mankind in the building of strong, resistant bodies and the prevention and cure of disease, their progress is sadly hampered by the faddist and the charlatan, who find them fruitful fields for exploitation. The wave of popularity has pushed dietotherapy from its embryonic stage into a paying proposition. The go-getter is aware of this fact and so he immediately attempts to ride in on the wave of popularity. As for actual knowledge, why worry about it. When ignorance is bliss and the shekels come rolling in, 'tis folly to be wise.

Sir George Newman has said "sound nutrition is fundamental in all phases of public and private health." Nutrition is a recognised fundamental and important keystone in any field of work, and yet it has been aptly remarked that, unless it be religion, there is no field of human thought in which sentiment and prejudice take the place of good judgment and logical thinking so completely as in dietetics.

Sir James Fraser in "The Golden Bough" relates many interesting superstitions regarding food. Among the taboos of the savages there were none more important than the prohibition to eat certain foods. The savage eats many plants and animals to acquire certain desirable qualities with which he believes them to be endowed, and avoids eating others because of the possibility of acquiring certain undesirable qualities.

In Madagascar soldiers dare not taste "hedgehog" as it is feared that this animal, for its propensity of coiling up into a ball when alarmed, will impart a timid, shrinking disposition to those who partake of it. They believe that if they were to eat cock which had died fighting, they would themselves be slain in battle. He who feeds on venison is swifter and more sagacious than the man who lives on the flesh of the bear, or fowl, or the slow-footed tame cattle, or the heavy, wallowing swine.

The Tapore Indians ate no heavy meats to impede their agility, but limited themselves to deer, birds, monkeys, and fish. Old men could eat tortoise freely, for they had already lost the power of running.

The Mamagus would not eat flesh of hare in fear that they might become faint-hearted as a hare. They would eat the flesh of a lion or drink the blood to get the courage and strength of these beasts.

The Miris of Assam prize tiger's flesh as food for men: it gives them strength and courage, but believe it not suited to women, as it will make them too strong-minded. People of Darfur in Central Africa think the liver is the seat of the soul, and that a man may enlarge his soul by eating the liver of an animal. Women are not allowed to eat the liver because they have no soul.

When sending out ships to a distant port, the women ate no sticky stuff such as rice boiled in cocoanut milk, for the stickiness of the food would clog the passage of the boat through the water; they were also forbidden to eat fish with sharp bones, lest those at sea would be involved in sharp, stinging trouble.

During war, at every meal, a little rice must be left in the pot and put aside, so the men far away will have something to eat and need never go hungry.

The Malay woman stripped the upper part of her body in reaping rice,

(Read at the annual meeting, 1931, Graduate Nurses Association of British Columbia.)

for she explained that she did it to make rice husks thinner, as she was tired of pounding thick-husked rice. She thought the less clothing she wore, the less husk there would be on the rice.

If you eat fruit that has fallen to the ground, you will yourself contract a disposition to stumble and fall; if you partake of something which has been forgotten, such as sweet potato in the pot, you will become forgetful.

Flesh diets of Egyptian kings were restricted to veal and goose. Many priests in antiquity abstained wholly from a flesh diet. The head chief of Mossai may eat nothing but milk, honey, and roasted liver of goats. If he should partake of any other food he would lose his power of soothsaying and compounding charms. There is a superstitious fear of the magic that may be wrought on a man through leaving of his food, and so savages have destroyed the refuse which, if left to rot, might have proved a source of disease and death. Superstition in this respect helped the sanitary conditions of tribes.

Savages believed that there were spirits in new vegetables and new fruits. At the present time in Lithuania, when new potatoes or loaves made from the new corn are being eaten, the people at the table pull each other's hair. The reason is obscure. When new potatoes are dug all the family must taste them, otherwise "the spirits in them take offence and the potatoes will not keep." Many people now always make a wish when eating the first fruit or vegetables of the season.

These superstitions concerning food are still prevalent among the savages of today, but there are many queer beliefs and theories equally ludicrous implanted in the mind of a great many of our well-educated people. Many of these have been handed down from generation to generation, and, regardless of the advancement of science, a large number of people cling to these old teachings.

For instance: Never eat orange or grapefruit if you are going to have cream on your cereal, for, as the saying goes, "it will sour on your stomach." Recently a graduate nurse, who was nursing in a well-to-do family, told me that her grapefruit or orange was always brought to her while in bed, so that it would be out of her stomach by the time she wished to drink her coffee with cream in it.

Never eat ice cream after eating lobster or fish of any kind, so some people claim. Why should everyone think this to be a dangerous combination, because one or two persons were not in fit condition to eat lobster or there may have been something wrong with either the lobster or the ice cream? No, it is the combination that is thought to be dangerous, and by being discussed widely thousands of people believe that by no means should they eat ice cream after lobster. Never drink milk when you are eating cucumbers. *Why not?* Do they not often serve a sour cream dressing with cucumbers? What other than souring happens to the milk when in the stomach, with or without cucumbers? I have heard of families who never have a vinegar dressing of any kind when having ice cream for dessert. These same families tell their little girls to eat crusts for they will make their hair curly; urge them to eat plenty of carrots to make them beautiful.

The following are some common food adages of today:

An apple a day keeps the doctor away.
Bread is the staff of life.
Celery is nerve food.
Fish is brain food.
Eat a beet to get red cheeks.
Lettuce produces sleep.
Onions keep away T.B.

"Don't drink water with your meals; it isn't good for you." Many youngsters suffer because of this remark reaching their parents' ears. It is far better to have it with their meals, if they are watched so they do not use it as a means to swallow their food more quickly than to go without sufficient water. Children are so busy

in school and in play that often they do not take the time to drink enough water for proper elimination.

In Mexico one hears, "Never eat peppers when in a rage." One can easily see how this superstition started, and now there are thousands who actually believe that any one in a very bad humour eating peppers will become very ill or even die.

Heretofore the liquor on canned peas, beans, etc., was always discarded as it was not thought fit to eat, but many people have learned that there are some soluble food principles in it, as well as a splendid flavour. All water used in cooking fresh vegetables was previously thrown away. Pediatricians always have to inform the new mothers how to prepare vegetables in order to use the water in which they are cooked.

In England there are many people who will not touch tomatoes. They believe they cause cancer.

You can probably call to your mind a dozen other similar fancies. They not only deal with persons in good health, but abound in treatments for the ill. The phrase, "Feed a cold and starve a fever" is familiar to all of you. Typhoids were given little nourishment: a little broth and a little milk: now they are often fed as high as five to six thousand calories a day. Of course, careful planning of reinforced foods is very necessary. We also believe now that the very best thing to do when we have a cold is to eat very little and drink plenty of water. So the old saying is changed to "Starve a cold and feed a fever."

Until the last few years obstetrical patients in hospitals were not allowed fruit and vegetables. Now any kind may be given if they agree with patient and babe. A person with rheumatism was never allowed any fruit. People even now when they feel a twinge of pain say, "Now I just won't eat any fruit for a while; that's a little twinge of rheumatism," even though it has been ascertained by scientists that citrus fruits have an alkaline reaction in the body.

Formerly tuberculosis patients were forced to eat raw eggs by the dozen. Authorities now say that forced feedings as frequently practised cannot be too emphatically condemned. Many patients have had their digestion permanently impaired and their chances of recovery seriously jeopardised by the forced milk and egg diet so widely in vogue. Both milk and eggs are very valuable articles of food, but to be permanently useful through long course of treatment they must be used with much discretion and moderation.

The fad of being thin still holds sway. In a recent popular article by Dr. Newburg he says that the world is divided into two classes of people: the fat ones getting thin and the thin ones getting thinner. Many different methods of reducing without effort are advertised. They depend for their sale largely upon the fact that the human race is essentially lazy: salts to be put in the bath, reducing soaps and ointments, the action of which was supposed to dissolve the fat chemically. Pills of various kind can be found on the market. Chewing gum under such attractive names as Sliph, Slendo, and Elfin have appeared. Some are harmless and ineffective. Others are effective but very harmful. "Going on diet" would seem to be the chief topic of conversation whenever women get together, and its effect is shown in our girls of 'teen age, who have a faulty conception of their nutritional requirements and proper weight. Dying of tuberculosis seems somehow a high price to pay for beauty. A boyish figure may look lovely in a casket, but who wants to get into a casket?

There are tables offered with two lists in parallel columns and it is absolutely forbidden to combine any food on one side with any on the other or dire results will follow; yet man has been doing so for centuries with more or less success.

Milk and fish are tabooed, and yet are not milk sauces used on fish by the best of chefs? It is difficult to

persuade people that orange juice and milk will not kill the baby and that milk and cherries are a safe combination so long as the person is normal; in case of sickness the doctor's orders must be followed. In some cases we do find a distinct food allergy or food anaphylaxis.

With the discovery of the existence of vitamines, almost miraculous cures were made of certain diseases, bringing vitamines very much to the fore. As in many other things, part of the scientific information on vitamines has been used for newspaper articles and advertisements recommending their use in tabloid form, yet the best source, as Mendel says, is the corner grocery with a liberal commonsense diet.

An adequate diet is the hub around which the wheel of life revolves.

1. It must contain sufficient calories to maintain normal weight.
2. The proteins of the diet must be adequate for growth and maintenance.
3. The residue or bulk of the diet should be sufficient to produce a normal bowel movement daily.
4. The mineral salts should be sufficient for body needs.
5. The diet should contain an abundant supply of vitamines.
6. The food must be palatable, available and suitable to the dietary habits of the individual.
7. Six to eight glasses of water as a body regulator and for elimination.
8. Exercise in the sunshine and fresh air and sufficient rest.

Then you'll all agree the six best doctors are sunshine, water, air, rest, exercise and diet.

Dr. John R. Murlin says controversy in science may be disconcerting to the layman, but it serves to sharpen our demands for unimpeachable and incontrovertible evidence. Without controversy we might be inclined to believe before being convinced.

With superstitions, old theories, new theories and theories yet to be unfolded, we feel that dietetics presents a most interesting laboratory. As long as we humans remain human we will have our foods, facts, fads and fancies.

Edwin Markman's verse recalls to us:

We are blind until we see
That, in the human plan,
Nothing is worth the making
If it does not make the man.
Why build these cities glorious
If man unbuilded goes?
In vain we build the world unless
The builder grows.

The Standpoint in History-Teaching

By Professor F. CLARKE, M.A., Professor of Education, McGill University

A deepening consciousness that the world in which we have to live, and still more, the world in which our children will have to live, must inevitably be a very different world from that of our forefathers, is compelling, slowly but surely, a thorough revision of the traditional content of education. What is happening is, not so much that we are casting out the old subjects in favour of new ones, as that we seek to revise our conceptions of the old subjects themselves. The old names, history, science, geography, and the rest, may be preserved, but we are now less sure than our forefathers were of what they ought to signify. The obvious futility of much school-work conducted on traditional lines does not escape us, and so we are forced to ask for subject after subject, whether the view we take of it as a teaching-instrument is really relevant to the need it is supposed to meet.

Of no subject is this more true than history, and no subject stands in greater need of a fundamental re-

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consideration of what we mean by it. Uneasy conviction that time spent in the study of it does not produce the expected fruit in enlightened social and individual conduct has caused general dissatisfaction with older conceptions, and an eager reaching-out for new forms of treatment that too often tries to compensate by enthusiasm for what it lacks in insight.

History as a chronicle, as a pageant, as a drama, as a great complex of human dynamics, as a social biology, as a repertoire of propaganda; none of these conceptions prove to be adequate for the purpose. They all fail in the crucial factor of self-reference; of placing the pupil herself with all her interests, immediate and remote, at the centre of the study; and of making her feel, with a glow of personal responsibility, that *De te fabula narratur*. "What is Hecuba to him or he to Hecuba?" we may say of all presentations of the human story that fail, in the end, to bring home to the pupil that the illumination of her present life and the convincing revelation of her personal duty is the real moral and burden of it. The message of it to her must be more than just "Go thou and do likewise." In spite of the great authority behind the opinion, history as a study is much more than philosophy teaching by examples. It is rather a true revelation of ourselves, a light from the past shining through our immediate world of life and duty today and giving it a colour of fullness and truth, without which we are as beings of but two dimensions, living in a *plane* of length and breadth—of mere here and now—instead of in a solid whole of continuing life, having *depth* as well.

To teach history at all vitally, then, is to shed a light on the life here and now of the learned, which solidifies, as by a stereoscope, the otherwise flat landscape of her immediate present. It should reveal to her a *continuum* of life, coming from a remote obscurity and moving onward to an unknown future, into which she has been dipped. With such a revelation it is no longer adequate to say of the individual, "From the great deep to the great deep he goes." The fleeting transience of the individual human life is literally overcome in the knowledge of history. That is its supreme value as a form of knowledge and that is the spirit in which it should be taught. To the well-taught pupil the past will no longer be that which was over and done with before she appeared on the scene, and the future no longer that which will happen after she is gone. If such a view of past and future were true and reasonable then we could all quite properly say, "Let us eat and drink for tomorrow we die," but we know quite well that it is not so. We realise, when we are true to ourselves, that the past, in so far as it has any meaning for us at all, is active and living in our present lives here and now, and that the future is already here in germ in the activities wherein we participate today.

Then the significance of the individual life becomes immensely enlarged. To be possessed of true historical knowledge relevant to one's place and work in life is to know oneself as not confined to the narrow mortality of this short span of individual existence. It is to become both the heir of all the ages that are past, and the maker of the ages to come. It means that, standing and working at this particular point in time which is ours, we are conscious of a living past within and about us, shaping the form of our actions, moulding our ideals, and above all, endowing us with the *confidence* that comes from a sense of our being so much more than appears. Similarly, a germinating future is about us too, adding to the firm confidence which is born of a live sense of the past, the lively hope of better things to be. If that which hath been is not merely to be repeated by that which shall be, it is we here on our own little bank and shoal of time who have to determine it so.

Historical knowledge, then, even more than scientific knowledge, is the great emancipator, expanding vision and releasing energy outward to the limits of time itself.

What should be the spirit of teaching which is to achieve this end? Much could be said, but here, as a sort of brief practical application of the general application of the general conception I have defined, I can only lay down one or two broad principles.

1. The starting point of all that is learned, and the focus of meaning to which it must all be brought back, is the immediate life and interests of the learner. This is the cardinal principle. *Illumination of the present life* is the end, either as a whole or in some particular aspect of it, e.g., the social activity of nursing. Hence that must be the focus of all the teaching.

Professional historians may have to launch themselves into the past *as such*, and to learn to see the past in its own right, as it were, without reference to its share in making the present. We shall all be the better for the effort, occasionally, to do the same thing, and in any case we must know the past as truly and as objectively as it can be known. For the ordinary citizen, with his task to fulfill, the significance of the past *in the present* must be the central idea that inspires the teaching.

2. History cannot be learned, still less taught, by those who have no sense of what it is to make history. Fortunately, the achieving of this sense is no high matter and the way is open to the humblest of us. We need no great place and power, the sway of millions or the command of armies. All that is wanted is the divine gift of imagination, playing freely upon the circumstances of our daily life and work. Reflect upon your daily duties, upon the social texture which determines their form and the social needs which give them value; upon the co-operation with the distant in place and time that is implied in your daily life; upon the customs you follow, the decisions you influence, the contributions you make to the common stock of good. Then you will realise that *life* which is the subject of history. For history is just *that*: that vast complex of human activities, thought of as having moved down to us where we are now, and as moving on still after we have gone, a little different because of our share in it.

3. Enthusiasm for common humanity is the driving force of the study. For those whose life-work is nursing, this should need no further elaboration.

4. Last, the mass of material is so enormous, so limitless, that we must know how to *select*. Here again one's own immediate life and interests must be the criterion. We can trace back through the intricately woven threads of the vast cable of history those strands which more directly connect with us and our own life and work today with the forefathers whom we so mistakenly call "dead."

As we do so, for we can do little more, let us remember all the time that the strands we trace are, after all, in a whole cable. Specialisation of interest is always dangerous, and we must beware of carrying it back too exclusively into our interpretation of the past. For history is one whole, one record of an enormously complex human endeavour, and I know of no special branch of it that needs more constantly to remind itself of the fact than the History of Nursing.

Impetigo Contagiosa

By GEORGE V. BEDFORD, M.D., Lecturer in Dermatology, University of Manitoba, Winnipeg

Impetigo contagiosa is an acute contagious disease of the skin, the result of an infection of streptococci, staphylococci, or both. It is characterised by vesicles, bullae, pustules and superficial crusts.

The term impetigo was used by the older authors in a much wider sense than it is now. It was first defined in 1796 by Robert Wilan, who is known as the father of modern dermatology. In 1864 Tilbury Fox used the term impetigo contagiosa.

The characteristic lesion may be considered to be a vesicle or a bulla, occurring chiefly on the uncovered parts of the body. The face is the most frequent site of the eruption. On such a part, where the epidermis is thin, the vesicle soon ruptures and the contents, in the form of a coagulable serum, produces an amber-coloured crust, which looks as if it had been stuck on. If this is removed a shining red base is revealed. If left undisturbed healing may take place beneath the crust, which then drops off, but the infection may spread at the edges almost indefinitely, giving rise to polycyclical figures. In parts where the horny layer is more resistant, the original lesions may persist and become filled with a yellowish serum, such lesions are common around the finger nails and form a superficial form of whitlow.

Impetigo contagiosa is usually conveyed by direct infection from one person to another, but it may be secondary to a discharging ear, a nasal discharge, or from scratching in scabies or pediculosis. Ecthyma is a term applied to those forms of suppurative infection in which actual destruction of the corium takes place, with consequent formation of ulcers. Sequeira states that this form of infection was frequently seen among soldiers during the war. It was usually secondary to scabies and pediculosis. The gluteal regions were the parts usually infected.

The diagnosis is usually not difficult. It may be confused with ringworm (tinea circinata), but the abundance of crusting, the greater number of lesions, the imperfect ring formation and the negative examination for fungi, would exclude a mycotic infection. Syphilis might resemble ecthyma. It must be remembered that any common itching eruption, as eczema, scabies, and prurigo, may become impetignised. True pemphigus is a chronic disease with marked constitutional symptoms.

Treatment: It is most important in treating this eruption to remove the crusts before using any local application. In mild cases the crusts can be removed mechanically by warm compresses of weak solutions (1-4000) of hydrarg. bichloride of potassium permanganate. Ordinary boracic solution or warm olive oil can be used.

Weak antiseptic applications are to be used in preference to stronger ones, as the latter lower the skin resistance. A favorite remedy with most practitioners is ungt. hydrarg. ammoniatum; this contains 5 per cent. of ammoniated mercury and is generally too strong; a 2 per cent. strength usually gives better results. This popular application is a very messy preparation and it usually runs all over the skin after melting. A more satisfactory application is composed of Lassar's paste with 2 per cent. hydrarg. ammoniatum

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added; this sticks on to the small lesions and it can be spread on gauze and applied to larger eruptions. Several other mild antiseptic ointments are used in treating this condition.

Five per cent. gentian violet in 50 per cent. alcohol is an excellent application. Two per cent. silver nitrate solution is useful particularly when there are lesions in the scalp and when a man has the infection in his beard.

A very old remedy used in the St. Louis Hospital of Paris for over a century is copper sulphate—grs. iv, zinc sulphate—grs. vi, in one ounce of rose water.

Vaccines are very seldom used today, although they are advocated in persistent cases.

Pemphigus Neonatorum—This is a bullous form of impetigo occurring in new-born infants. It frequently occurs in epidemics in maternity wards of public institutions. Any part of the body may be affected. The lesions develop at variable periods after birth. They are generally vesicles of bullae with serous or purulent contents.

In some of the severe cases the horny layer is stripped off the whole surface of the body, this is known as Ritter's disease or exfoliativa dermatitis of the new-born. This disease is an extremely fatal one.

Benians and Jones investigated thoroughly two epidemics of this disease. A summary of their investigations is recorded in the British Medical Annual of 1930.

The authors draw the following conclusions: (1) "Pemphigus neonatorum is due to a primary infection with staphylococcus aureus, that is one indistinguishable biochemically and culturally from the S. pyogenes aureus. (2) In most cases the primary source of infection can be traced to a septic focus on the mother, or on one of the attendants who come directly or indirectly in contact with the infant. In the author's cases the septic focus was in nearly every case of the blister type, and they consider that probably this type of lesion is much more apt to lead to pemphigus infection than the commoner type of staphylococcal lesions such as follicular abscesses. (3) S. aureus is frequently found in the throat and milk of mothers before and after child-birth, but this cannot be considered the usual primary source of infection. (4) In fatal cases it is found that the umbilicus has usually become inflamed, and it should therefore always be kept as clean as possible. (5) Their experiments, although limited in number, do not support the thesis of a filterable virus." Diagnosis—These cases are liable to be confused with the bullous lesions of congenital lues, which is a symmetrical eruption, occurring chiefly on the palms, soles and in the ano-genital region. The bullae are less tense than the impetiginous lesions and they generally have a discoloured and infiltrated base. This type of congenital syphilid usually appears within a few days after birth. A luetic baby would likely show general signs such as wasting and snuffles. Treatment—If a case of pemphigus neonatorum is discovered in a maternity ward of a hospital, the mother and baby should be isolated and stringent precautions should be taken to prevent spreading the infection.

The blebs should be opened with a sterile needle and then pure alcohol applied to the affected areas. Various local applications may be used, e.g., 1 per cent. hydrarg. ammoniatum in cintment or in calamine liniment; gentian violet, 5 per cent in 50 per cent. alcohol. Care should be taken not to apply lotions to large areas of the body, as they cause loss of heat.

Soap and water should not be used on the affected parts; sponging with potassium permanganate solution (1-4000) is to be preferred.

If the infant has lesions on the face the mother's breasts must be protected from infection.

Department of Nursing Education

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A Curriculum for Schools of Nursing in Canada

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I. Introduction.

The date, 1929, is one long to be remembered by Canadian nurses: in July of that year The International Council of Nurses met in Montreal; in November of the same year the Director of the Survey on Nursing in Canada reported at the office established in Toronto as headquarters for the work, and the Survey was "on." The report of the Committee on Nursing Education of The International Council of Nurses presented at that July, 1929, meeting drew attention to the need for further work on the Curricula of Schools of Nursing. Dr. Weir's report will undoubtedly stress a need, as shown in very many of our Canadian schools, for help in formulating their curricula; every thoughtful nurse educator has herself recognised the need. The Nursing Education Section of the Canadian Nurses Association has placed in the hands of the directors of Canadian schools of nursing excerpts from the I.C.N. Report—using this as a basis for our work during the coming year we ask your co-operation in formulating the skeleton, at least, of a curriculum which will indicate minimum standards as well as suggesting more desirable developments in our school of nursing programme. As stated in an earlier reference to this suggested curriculum, comments are invited—they may be sent directly to the Editor of *The Canadian Nurse* for publication, or to the Chairman of the Nursing Education Section.

II. Objectives.

It seems very clear that before any programme can be arranged we must know our aims or objectives. Two comprehensive aims are stated on page 5 of the I.C.N. Committee Report, which may be very briefly stated as:

(1) To place nursing service and nursing education on a full professional basis, and to produce in our schools not only trained nurses but educated nurses.

(2) To broaden the conception of nursing service to include the nursing care of the whole patient, mind as well as body; attention to the whole environment, social as well as physical; to the prevention of sickness as well as the bedside care of the sick, and health service to families and communities as well as to individuals.

Some nurses may not yet have given much thought to the need for study of our objectives in Nursing Education, and in the more isolated schools the superintendents lack the opportunity to discuss the subject. That we may make the most of work that has already been accomplished, your attention is directed to a discussion of "Practical Objectives" as presented by a special committee of the National League of Nursing Education (United States). For this reference turn to pages 46-51 of the Curriculum for Schools of Nursing as revised and published by the National League of Nursing Education in 1927. In the field of General Education read such

a book as Bobbitt's "How to Make a Curriculum"; study especially the Main Objectives of Education as presented in chapter 2. We are, I am sure, agreed that the curriculum of every school for nurses should be sufficiently comprehensive to embrace the two main objectives as quoted from the I.C.N. Report, and that in no case should this programme be appreciably curtailed by the limitations of the institution, and yet offered to the student as a complete course in nursing. If a school of nursing is to be established, it must not be with the thought of meeting the needs of the institution by providing the personnel of the nursing staff, but rather with the aim of equipping students to meet the present and future health needs of any average community.

Let us, then, following the I.C.N. Report, consider some of the facilities and conditions essential for the establishment of a good school of nursing.

III. Facilities and Conditions Necessary for the Establishment of a Good School of Nursing.

(1) Type of Hospital:

Nurses will agree that a general hospital is the one most likely to have all services which are essential for a well-rounded training; as well as a variety of cases. It is most likely to have the various types in sufficient number to provide for all pupils practical experience in the nursing care of each type (this depends also on the size of the hospital, which will be discussed later). It is generally agreed that the following services are essential to provide a well-balanced course of training: Medical, Surgical, Pediatrics (including medical and surgical and the care of children from infancy up), Obstetrics, Communicable Diseases, and Dietetics. The following services are also of great importance and should probably be considered essential: Psychiatric Service, Out-Patient and Social Service. Each superintendent of nurses should ask herself, "Does this hospital provide adequate facilities for instruction in each of these departments?—if not, is there a reasonable hope that the departments which are lacking will soon be organised, or might I arrange a satisfactory affiliation for certain of these services?"

(2) Capacity of Hospital:

As indicated above, the size of the hospital and the daily average number of patients must be considered as well as the variety of services. It is rather generally agreed that a general hospital of one hundred beds, with an average of seventy-five per cent. of the beds occupied, is the smallest hospital which, without affiliation, can expect to provide adequate facilities for experience in all of the essential services. Many consider that two hundred beds should be the minimum in a hospital conducting a school of nursing.

(3) Financial Resources:

It should not be necessary to state that every school of nursing should have a definite yearly budget. In the opinion of the committee, the source of its revenue should not be fees paid by the patient for care during illness. Too long have schools of nursing been established because the hospital directors thought that the cost of the care of the patients would otherwise be prohibitive. Until more accurate information in regard to the actual cost of the maintenance of the school in hospitals of different sizes is available it is impossible to meet this argument. On the other hand, the institution's need should not be the decisive factor. That a school may be intelligently conducted the superintendent must know what her allowance is, and that the school may be progressive the budget must be sufficiently generous to allow of development.

If our schools of nursing are really professional schools, there should be no difficulty in securing Government grants towards their maintenance, and generous contributions from private sources will also follow in time.

IV. Personnel of Staff.

A school of nursing must be staffed with a sufficient number of graduate nurses to give adequate instruction in the class-rooms and adequate instruction and supervision on the wards. The wards should also be staffed with a sufficient number of graduate nurses to safely carry the load of the routine daily care of the patients. The care of the patient must not be secondary to the education of the student: on the other hand, the student's educational programme must not be curtailed in order to meet either the routine or unexpected demands of the wards.

Until recent years no special training was available for nurses wishing to enter upon teaching or administrative posts. Instructors were frequently selected from nurses who, before entering the school of nursing, had received a normal school training. Courses have now been established in a number of universities in Canada, and this special preparation should undoubtedly be required of all recent graduates desiring to undertake teaching or executive work.

V. Special Hospitals.

Schools of nursing have been organised in various types of special hospitals: children's hospitals, mental hospitals, maternity hospitals and sanatoria. It is a debatable question as to which should absorb the major portion of the student's time, the special hospital or the general hospital with which it is affiliated. If, after graduation, the nurse trained in a special hospital were to nurse exclusively in that field of duty the question would be easily answered. Since, however, affiliations are arranged that the nurse may become a registered nurse, qualified to practise any branch of nursing, the question is an important one. Within the specialised fields, opinion, rather naturally, favours the student commencing her training in the special field and spending the major portion of her time there. The general weight of opinion, however, falls to the other side, in favour of the student commencing and spending the greater portion of her time in the general hospital. Many regret the enrolment of new students in any special hospital, and urge all special hospitals to organise courses suitable for affiliate students from the different general hospitals. If, to carry out the more simple routine tasks, a type of ward assistant must be trained, care should be taken that the education of the two groups is carried out upon quite distinct levels.

In regard to a term of affiliation with special hospitals, it is recommended that where the services are lacking or inadequate in the general hospital, students might be sent for the following terms: Children's hospital, three months; psychiatric hospital or department, three months; sanatoria, two months; communicable diseases, two months.

VI. Housing and Living Conditions.

Since conditions of hospital service make it almost essential that student nurses should be in residence, suitable provision must be made in regard to sleeping quarters, recreation facilities and facilities for studying.

For sleeping quarters, single rooms with running water are favoured, and nothing larger than a two-bed room should be considered. Reception and recreation rooms should be provided, and provision for such sports as tennis, badminton and swimming should be made if at all possible.

Ample provision should be made in the nurses' home in regard to baths, toilets and laundry facilities; suitable wash rooms should also be provided in the hospital.

The dining room should be attractive, and its capacity should be such that by a suitable arrangement of meal hours all students will be allowed a generous time for meals.

VII. Class Rooms, Library and Study or Reading Rooms.

While undoubtedly the major portion of the student's time will continue to be spent on the wards, 9-11

hours being as a rule spent in the ward to one hour in the class-room, yet well-equipped demonstration and class-rooms (varying in size and number according to the size of the school) are essential. A well-stocked professional library, with competent supervision, is essential, and reading or study rooms are very important.

VIII. Standards of Admission to Schools of Nursing.

If nursing is to be regarded as a profession, and one which should attract the very best type of young women, there must be a definite educational entrance standard, and that standard should not be lower than the standard required for admission to the other professional schools. While conditions fifteen or twenty years ago were such that only a small percentage of young women were high school graduates, and conditions within the schools of nursing were such that the majority of high school graduates were not attracted to nursing, such conditions have changed. There are few communities in which high schools are not within a reasonable distance, and a secondary education is available to anyone desiring it. The committee feels that unquestionably the educational admission standard should be junior matriculation or high school graduation.

Details of a suggested course of study will follow in the next issue of the *Journal*.

References

Report of the Committee on Nursing Education of the International Council of Nurses.—Any superintendent of nurses who has not received a copy of the report should write to the Convener of the Nursing Education Section of her Provincial Nurses Association.

Curriculum for Schools of Nursing—This may be purchased through the American Journal of Nursing, 450 Seventh Avenue, New York.

How to Make a Curriculum—Bobbitt. Publisher—Houghton & Mifflin, 2 Park Street, Boston.

Comment on Successful Curriculum for Schools of Nursing

It is encouraging to all interested in the education of student nurses to know that a Committee of the Nursing Education Section of the Canadian Nurses Association is giving very serious thought and study to the development of a standard minimum curriculum. In this number of *The Canadian Nurse* a beginning has been made in the publication of the first section of a suggested Curriculum for Schools of Nursing. In this article we learn of other similar studies and where the information already compiled may be secured. All these suggestions are most helpful and will be very useful in the work undertaken.

It would seem, however, that before any curriculum can be effectively developed and put into practice the hospital in which the student is receiving her education should be given some consideration. This is discussed in the article mentioned above under the heading "Type of Hospital." Judging from the present conditions found in hospitals, the average institution definitely plans to conduct its nursing service with student nurses regardless of the practical experience in nursing the hospital has to offer. Schools are conducted in all types of special hospitals, and in many cases directly under the control of the provincial and municipal governments. In some instances, all too few however, affiliation is arranged which usually provides the bare minimum of practical experience by which the student may qualify for governmental recognition. Then, too, the small hospital often offering less real nursing experience than the special hospital conducts a school of nursing without feeling any responsibility or even recognising the necessity of providing additional experience for its students.

The Registration for Nurses Acts in the different provinces have assisted to a certain degree in raising the general standard of nursing education, but the legislation does not

really meet the situation as it exists. Amendments to the existing Registration Acts should be made, by which hospitals that have not the necessary experience to give the student group an adequate practical training should be prohibited from conducting schools of nursing. The present form of legislation has proved beyond all doubt that it is not sufficient protection to nursing education to permit the individual hospital to decide whether it wishes to meet the requirements by which its graduates may be able to qualify for registration in the province. The standing of the graduates of the school does not seem to be of any interest to the hospital administrators faced with the problem of nursing the patients in their own special institution. For too long Boards of Trustees have advanced economic reasons for maintaining a student nurse service. In many cases, if the facts were studied, it would be found that taking all factors into consideration nursing by means of a student group is not the most economic plan.

In any case, why should the nursing service be made responsible for balancing the hospital budget? It is too serious a question to be settled in that way, especially when one considers the qualifications with which these graduates enter upon their professional work after graduation. Whether they qualify as registered nurses or not, they immediately seek employment, and their training and preparation ceases to be an isolated question affecting one institution only and becomes a public problem affecting all to whom those nurses may be called to give nursing care. The argument advanced in defence of this practice is that these hospitals are needed in the communities they serve. If so, they should be entitled to sufficient Government subsidy to balance their budget without being required to do so by a so-called cheap nursing service.

The starting point of a standard nursing curriculum is the hospital in which that curriculum is to be put into practice. Legislation should be secured by which any hospital educating nurses would be required to meet a definite standard in relation to the number and type of patients treated. That standard should be determined only from an educational standpoint, taking into consideration the different branches of practical nursing experience provided directly by the hospital or through adequate affiliation. Such legislation should discourage the continuance of schools in special hospitals and encourage these hospitals to secure affiliation by which general hospitals would send students for this special branch of training.

The report of the Joint Study Committee on the Survey of Nursing in Canada, which will be ready for publication this autumn, should provide very convincing reasons why this legislation should be enforced. Until hospitals are prohibited from conducting schools unless they meet the minimum requirements in reference to nursing experience there will not be any outstanding improvement in present methods of nursing education. The schools already meeting the minimum standard will nc doubt change and improve their methods and will be benefitted by the findings and suggestions of the committee. However, the greatest need for improvement is found in the schools which will remain largely unaffected by and unresponsive to any suggestions or recommendations and which will continue to add their quota year by year to the members of the nursing profession in this country. To bring into operation legislation which will make this practice impossible would seem to be the logical starting point in the development of a standard curriculum in Canadian Schools of Nursing.

J. I. G.

[Editor's Note It is suggested that readers refer to The Canadian Nurse, May, 1931, page 254, and that they note further comment on the foregoing first installment of A Suggested Minimum Standard Curriculum for Schools of Nursing in Canada is invited. The remaining sections of the Suggested Curriculum will appear in later issues of the Journal.]

Department of Private Duty Nursing

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Suggestive Elements in Medical Care

By Dr. ROBERT G. ARMOUR, Toronto

In choosing the subject of my paper, I have used a title which is intended to be indefinite for fear that I might discourage some of you from listening to it, thinking it may be either not of importance in your particular work or because you might think that you cannot understand it.

Neither is the case. There is no branch of nursing in which suggestion cannot play a part, and anybody who can nurse can understand what I am about to say and should know something about the subject.

What I mean by suggestion, is the acceptance by any individual of something that has been said, and also the interpretation by them of other circumstances such as the attitude, demeanour and every action of those about them.

Suggestion has been defined as "the acceptance with conviction of a communication." So far I am in agreement. Certainly there must be conviction. But the definition goes on to say "in the absence of logically adequate grounds for its acceptance." Without going too deeply into this I would say that your suggestions should have at least the semblance of logic, they should appeal to the patient's reason, especially if they are to combat the possible return of doubts and misgivings.

If suggestion is to be of permanent use, surely its action must be permanent and lasting, and yet, even if it is accepted for the moment, counter-suggestions may enter the field in the form of these doubts or misgivings in the patient himself, or may be advanced by relatives and friends who are later discussing the case.

Over-enthusiasm, as one makes helpful suggestions, may infect the patient and carry him along. When such a patient has more time to think, his enthusiasm may cool off, and he may not feel so firmly convinced in the direction one is trying to lead him. The more logical the suggestion, the more it appeals to his reason, the more will the patient remain convinced. Many a person has been possessed of a certain mistaken idea for many years. This idea must be broken down and corrected in perhaps an hour's time. One must give the patient reason for dropping the old idea and taking up the new, and it seems obvious that this should be a logical process and not a passing enthusiasm.

If I might digress for a moment, much suffering, even when dependent on mistaken ideas, arises in the emotional sphere of the patient's mind. The emotion of enthusiasm has a temporary place in correcting this, but the lasting effect must come from the substituting of intellect for emotion.

Suggestion has often been given to patients under the influence of hypnotism. I have one grave criticism of this. Though the patient may be cured of his complaint, he believes he has been cured by, and is dependent upon, the physician who hypnotised him.

How much more secure he would be if he had been cured by the con-

(An address given at the annual meeting of the Registered Nurses Association of Ontario, April, 1931.)

scious exercise of his own intellect? Could he not in many instances avoid further attacks, or if others should develop, could he not find his own way out?

I realise that I am presupposing an intellect in the patient. Sometimes it is not there and one has to use physical means to effect the cure, such as drugs, blisters, lumbar punctures, or other means of demonstrating to the patient that something is being done for him.

I have drawn above from William McDougall's definition of suggestion. I prefer Dubois' insistence that suggestion should incorporate education. What is said or done in the presence of a sick person suffering from disease may have much to do with the progress of that disease either for better or for worse: depending on whether they receive proper instruction and encouragement, or if left with their own mistaken ideas, or, given others, they act to their own prejudice and receive discouragement.

I am not dealing with functional nervous disturbances only. Let us consider a heart case. The diseased heart is most likely to beat too fast. Effort makes it beat faster, and so we put the patient to bed. But do not fear and anxiety make a heart beat fast? Are we accomplishing the desired rest if we remove only exertion as a cause of increased heart rate, and yet leave fear and anxiety accelerating it?

And so with a gastric disturbance. Does any one of you eat so well and digest so thoroughly if ill-humoured, depressed, excited, fearful, or if disturbed by any other emotional excess? Have you never seen a person vomit from grief or fear? Have you never seen a person sit down and eat a good meal and have a restful sleep after an emotional strain is over or after they have received reassurance.

How often have any of you heard a patient told, "Oh, a friend of mine was like you once, and she has never been able to do anything since," or, "and it turned out to be cancer." This is a form of suggestion, possibly more common than beneficent suggestion, and the cause of much misery and invalidism in the world. What a few simple and authoritative words might do to correct or combat these remarks. Both are suggestions, one harmful, the other helpful.

It is a characteristic of human beings, when they discover anything about themselves which appears to be unusual, whether it be painful or painless, that they are likely to interpret it as indicating something wrong, as constituting a symptom of ill-health, as signifying some disease, and in their ignorance and mistaken ideas of medicine, they almost always, under these circumstances, apprehend the most dreadful disease of which they have knowledge.

Here we are dealing with another form of suggestion, auto-suggestion. Auto-suggestion is just the putting into effect some recollection or fear that has been latent in the patient's mind in times when he was not so suggestible. At the psychological moment this fear seems to be realised, he is convinced that he has the disease he always feared.

To my mind this is a much more charitable, and much more accurate explanation of functional nervous states, or mental reactions to organic disease than to say his condition is just the result of his imagination, which suggests a deliberate mental effort, with conscious moral responsibility.

Such people can be confirmed in these fears by an attitude of alarm on the part of those about them. They are only too ready under ordinary circumstances to receive or accept the reassurance of those in whom they have confidence and who seem qualified to reassure them. This might help to disprove the theory of imagination. But many such people are unusually sensitive, and tact is required in giving reassurance for fear that a patient will think that his troubles are being be-littled or that

those about him are being unsympathetic.

Many a patient comes to the doctor with a certain uneasiness, fearing disease in some system. Unfortunately it is all too common for the doctor to agree with him or, without making any comment, give him some medicine which would imply his agreement. This may confirm the fear.

Again the doctor may not agree with him, but without listening very carefully to all that the patient wants to say, and without examining him with particular care, he may tell him bluntly that this disease does not exist.

This latter attitude brings up for consideration at once, one of the most important elements in suggestion, namely, the prestige of the suggestor, which I will deal with elsewhere; it will be sufficient for the present to say that this patient will be dissatisfied and will not accept the suggestion which might have acted for his good.

The nurse may dismiss a complaint too abruptly to reassure the patient. She may even, in a case which has been a trying one, dismiss the complaint somewhat impatiently, and even find herself saying, "You are always complaining of something." I do not need to tell you how this will drive the patient back into himself to suffer his uneasiness without opportunity for comfort, and may destroy the opportunity for enlightening him.

I have referred above to the prestige of the suggestion. What do we mean by this, and how does it act? We often say, "Oh, I wouldn't believe anything he said," or "I wouldn't take him too seriously." Such a person has little or no prestige when it comes to suggestion. Of another we express unbounded confidence. His prestige is great. All his sayings will carry weight.

It behooves us then to study how one's prestige may be developed. A reputation built up over a long number of years helps to cultivate it, always provided this reputation reaches the ears of the person about to receive the suggestion.

Prestige may be shown by the way a person walks into the room, his speech, his method of examining or handling the patient. The appearance of self-confidence makes for prestige.

Tact and firmness, with good humour, but most of all, dignity, self-restraint, and justice are most valuable aids. Thoroughness, both in listening to complaints, investigating them, and acting for their relief, all make for prestige and make it more likely that the patient will accept the dictates of the individual exhibiting these properties.

My purpose, then, will appear not to be suggesting that you as nurses, necessarily begin to practise psychotherapy for the cure of your cases, especially in organic diseases, but to impress upon you how your cheerful confidence and patient, charitable attention to complaints may do much to help the patient toward a cure.

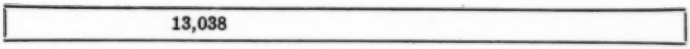
I am sure that the warning implied in my remarks on faulty suggestion need not apply to any one of you, but perhaps you are not all aware how visitors and relatives either unthinkingly, or for the morbid sake of creating a sensation, may drop a chance remark that may do great harm. And more difficult still to guard against, is that form of auto-suggestion contained in the patient's recollections, fears, and misgivings.

SCHOLARSHIPS AWARDED

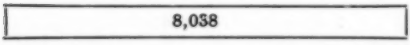
After awarding the Flora Madeline Shaw Scholarship, for 1931, to Miss Flora Gladys MacKeen, a graduate of the Royal Victoria Hospital, Montreal, the committee directing this Memorial Scholarship Fund decided, in view of general economic conditions, it was advisable to assist two more nurses in post-graduate study during the coming year. Therefore, scholarships of $250.00 each have been given to Miss Madeline Flander, Children's Memorial Hospital, Montreal, and Miss Nora C. Martin, Jeffrey Hales' Hospital, Quebec City.

These nurses who graduated in 1929, possess exceptional ability, and will attend the School for Graduate Nurses, McGill University, as members of the Course in Teaching in Schools of Nursing.

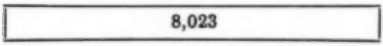
Canadian Nurses Association



Total Membership 1929. Levy 50c per capita.



Membership Provincial Associations 1929.



Total Membership 1930. Levy 75c per capita.

CHART I.

$5,519.00. Total Revenue 1929.

$6,017.25. Total Revenue 1930.

$6,491.50. Budget adopted 1930.

CHART II.

These charts were prepared to show the effect in membership and revenue from fees resulting from national affiliation being limited to the nine Provincial Associations of Registered Nurses in Canada, as decided by unanimous vote at the Biennial Meeting of the Canadian Nurses Association, 1930.

While it was anticipated there would be a marked decrease in national membership when the alumnae associations withdrew from direct affiliation, it was hoped *that* decrease would be lessened by an increase in membership in the provincial associations. However, Chart I shows this has not occurred. It must be kept in mind that slight reverses may be expected during a transition period, which in the present situation should be somewhat remedied when reports on membership for the present year reach the National Office.

In view of the decrease in membership, the official representatives at the Biennial Meeting of 1930 voted to increase the per capita annual affiliation fee from fifty cents to seventy-five cents. The same representatives approved an annual budget amounting to $6,491.50 for the years 1931 and 1932. Chart II shows a comparison of revenue for 1929 and 1930 and also the amount approved for the budget for 1931 and 1932—the fees for national affiliation are estimated on the membership of the affiliated organisations for the previous year, hence fees received early in 1931 represented the total provincial membership for 1930.

News Notes

ALBERTA

HOLY CROSS HOSPITAL, CALGARY: Twenty years after the first nurses graduated, the Holy Cross Hospital Training School organised its Alumnae Association when on May 7th, 1931, one hundred and sixty nurses gathered at the hospital to renew acquaintance with old friends and to meet the new graduates. The Sisters, ever ready to help make any onward step a success, threw themselves heart and soul into the work of preparing for the first meeting. During the past twenty years there have been over three hundred nurses graduate from the school, and nearly all of these were notified by letter of the plan of the Association. A large number quickly responded by letter or in person and all declared themselves overjoyed that at last they could be banded into a united body. The Study Hall was tastefully decorated with flowers and plants, and the nurses were received by the Sister Superior, St. Jean de l'Eucharistie and her assistant, Sister Weeks, who was for so many years the beloved Superintendent of Nurses. Miss M. Brown, who has the honour of being the first Holy Cross Hospital graduate, was asked to take the chair, and Rev. Father Cameron addressed the nurses, outlining the object of an alumnae and encouraging the assembled company to become united. The chairman then appointed a committee to select officers. Mrs. de Satge was elected president, Miss Zimmerman, vice-president, Mrs. W. R. Cope secretary, and Mrs. T. Drinkwater assistant secretary. A lunch was served by the 1931 class.

On July 8th the Alumnae Association held a garden party at the home of Mrs. W. R. Cope. Socially and financially this event was a great success; over fifty dollars was raised towards funds for developing of the recently formed alumnae.

EDMONTON ASSOCIATION OF GRADUATE NURSES: Miss Fanny Munro, who spent the past year in post graduate work at Teacher's College, Columbia University, New York, has resumed her duties as Superintendent of Nurses, Royal Alexandra Hospital.

Miss B. F. Fetterly, of Vancouver, visited relatives and friends in Edmonton and district during July and August.

Miss S. S. Christensen spent a very enjoyable holiday at Vancouver and Victoria.

Friends of Miss Dorothea Engelcke are pleased to hear that she is convalescing at her home after a lengthy illness.

Miss Frances Macmillan, Superintendent of Nurses, Methodist Hospital, Indianapolis, Ind., was a visitor in the city recently.

Miss A. L. Young motored to Vancouver where she is spending a month's vacation.

BRITISH COLUMBIA

ST. JOSEPH'S HOSPITAL, VICTORIA: The annual meeting of the Alumnae was held in the Nurses Home on June 6th. The election of officers was as follows: President, Miss E. Cameron; First Vice-President, Mrs. Evelyn Stibbart; Second Vice-President, Mrs. Elizabeth Lewis; Treasurer, Miss Kathleen Fraser; Rec. Secretary, Miss Isobel McMillan; Cor. Secretary, Miss Helen Cruikshanks; Councillors, Mrs. F. M. Bryant, Mrs. Harry Beoch, Misses Bessie Graham and Nell Meagher. After all business was completed a supper was given in the reception hall. About thirty-five members attended this happy reunion.

A meeting of the members of the Alumnae was held in the Nurses Home on July 15th in honour of Sister Mary Mildred, whose six-year term as Sister Superior of St. Joseph's Hospital had expired. Miss E. Cameron, president, voiced deep regret that Sister Mary Mildred's period of office was ended, and presented her with a missal as a small token of appreciation of the many kindnesses and excellent advice which she was always ready to tender. Mrs. F. M. Bryant and Mrs. Elizabeth Lewis presided over the tea table during the social hour in which a large gathering of members and friends participated.

MANITOBA

WINNIPEG GENERAL HOSPITAL: Miss Raby Johnson (1927), of the Children's Hospital, Detroit, Mich., visited in Winnipeg during the early summer. Miss S. J. Pollexfen (1917), has just returned from a delightful holiday spent in California. Miss Margaret Beckman (1927), is visiting in Winnipeg from New York. Miss Helen Gugin (1929), has resigned from the staff of the Social Service Department, Winnipeg General Hospital. Miss Geraldine Hayden (1921), and Miss Constance Lethbridge (1925), have motored east to Halifax and Boston for a holiday. Miss Ivybelle Webster (1930), relieved on the staff of the Social Service Department of the Winnipeg General Hospital during the summer months. Miss Kate Findlay has accepted a position on the staff of the Port Arthur General Hospital. Miss Edith McCorquodale (1920), is relieving on the staff during the summer months. Miss Mabel F. Gray (1907), of Vancouver, visited in Winnipeg during July and August. Mrs. E. H. Alexander (Marie Breden, 1920), has returned to the city after spending the past year in England and on the continent. Misses Mary Goodall and Winona Spence of 1930, Bertha Bethal, Christina Dawson, Alberta Gilbert, Isabel McLennan, Margaret Waugh and Edith Orton, of 1931, are at present doing post graduate work in the Hospital. The sympathy of the Alumnae

is extended to Miss Margaret Waugh (1931), on the death of her mother, and to Miss Millie Henderson (1928), on the death of her father.

NEW BRUNSWICK

HOTEL DIEU HOSPITAL, CAMPBELLTOWN: The graduating exercises of the St. Joseph's School of Nursing, Hotel Dieu Hospital, were held in the Auditorium of the High School on the evening of May 12th. Five young ladies received their diplomas. The exercises were presided over by the President of the Medical Staff, Dr. L. G. Pinault, F.A.C.S., and the diplomas were presented by His Excellency P. A. Chiasson, D.D., Bishop of Chatham. Rt. Reverend Monseignor A. Melanson, P.A., V.G., and Reverend J. M. Hill, Rector of St. Thomas College, Chatham, were among the speakers of the evening. The exercises closed with the graduates taking the pledge of the Catholic Nurse. The stage, prettily decorated with flowers and school colours, purple and gold, made a colourful background for the occasion. An informal reception at Lourdes, the Nurses Residence, followed the exercises.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in August, 1931, were 1,022, twenty-six more than in July, 1931.

APPOINTMENTS

HOSPITAL FOR SICK CHILDREN, TORONTO: Miss Mary Leslie (1925) has accepted a position on the Public Health staff at Charlottetown, Prince Edward Island. Miss Helen McCallum (1930) is in charge of the Infant Ward, Montreal General Hospital.

Miss Lucas (Grant MacDonald Training School, Toronto, 1929) has been appointed to the staff of the Victorian Order of Nurses, Halifax, following a year in Public Health Nursing at the School for Graduate Nurses, McGill University, Montreal.

GENERAL HOSPITAL, BELLEVILLE: Miss Marie Yeomans (1931) has accepted a position at St. Agathe des Monts Hospital, P.Q. Miss Harriet Stacey has been appointed Superintendent of the Hospital at Hamilton, Montana.

Miss Doris Bailey (Hospital for Sick Children, Toronto, 1929), has joined the staff of The Children's Hospital, Winnipeg, Man.

OTTAWA: Miss Betty I. Taylor, a graduate of the Lady Stanley Training School for Nurses, Ottawa, has been given appointment as a missionary nurse under the American Board of Commissioners for Foreign Missions and assigned to the Albert Victor Hospital, Madura, India. Miss Taylor is the first nurse from North America to serve in this institution.

Miss Ethel Wilson (Homewood Sanitarium, Guelph, Ont., 1930), has been appointed a floor supervisor in that institution.

DISTRICT 2

GENERAL HOSPITAL, BRANTFORD: Miss Winnie L. Chute, B.A., Reg. N., Director of Nurse Education, Brantford General Hospital, has been awarded a fellowship by the Rockefeller Foundation. Miss Chute will study Physiology at the University of Toronto with Dr. Charles Best. While extending congratulations and best wishes for her future success, the entire hospital personnel regrets Miss Chute's departure. Miss Chute received her Bachelor of Arts degree at Acadia University, and her nursing education was acquired at the Royal Victoria Hospital and McGill University, Montreal. Miss Clara Jackson (Montreal General Hospital, 1922) recently completed a course in administration and teaching at the School for Graduate Nurses, McGill University, and has been appointed Director of Nurse Education, Brantford General Hospital.

GODERICH: Miss Ella C. Watts (Victoria Hospital, London, Ont., June, 1927), who for the past year has been attending the University of Western Ontario, has accepted the position as Science Instructor in the Mercer Hospital, Trenton, New Jersey.

GALT: The summer meeting of District No. 2, R.N.A.O., was held at the Nurses Residence of the Galt General Hospital on June 17th, 1931. It was an open meeting, at which section topics were given. A lesson plan on Anatomy of the Kidney, and the manner of presentation, was admirably given by Miss W. Chute, Instructor of the Brantford General Hospital. Miss Henrietta Kerr, Victorian Order Nurse, Brantford, gave an excellent practical demonstration of a visit to a private home. An interesting and instructive paper on the nursing care of several types of mental cases was read by Miss Mae Davison, Woodstock. Miss Dodds, of Brantford, talked on the value of pension bond type of insurance to the professional woman. After a delightful tea served on the porch by the members of the Galt Alumnae, the meeting adjourned.

GUELPH: Graduation exercises of St. Joseph's Hospital, Guelph, took place in the Collegiate Auditorium on June 5th, 1931, when fifteen nurses received diplomas and pins. Rev. Father Monaghan delivered the address to the class. Dr. H. O. Howitt presented the diplomas and Dr. W. V. Harcourt, the pins.

The graduates were:—Sister Mary St. Paul, Sister Mary Clothilde, Misses Irene St. Marie, M. L. Aitchison, Marie Harrett, Reta Waechter, Myrtle Gainer, M. E. Boyle, M. Gowdie, M. G. McComb, P. A. Norris, L. A. Malone, Thelma Hammond, M. T. Dudgeon, A. M. Savage.

KITCHENER: In a steady downpour of rain the Rotarian's Eighth Annual Clinic, for crippled and defective children, of Waterloo County, was held at the Kitchener-Waterloo Hospital, on May 30th, 1931. One hundred and thirty-five orthopedic and neurological cases were examined during the day, forty to fifty of them being new cases, the remainder for re-examination. Doctors

Robertson, McDonald and Boyer, specialists from Toronto, conducted the examination, and local physicians and nurses assisted. The Rotarians gave their time and cars to facilitate transportation of children and parents. Each year, in this way, it is made possible for these children to obtain expert opinion free of charge, and when special treatment or surgery in Toronto is advised, the Rotarians arrange transportation and pay hospital bills if the parents are unable to do so. An average of 120 children are received at the clinic annually, about one third of this number being new cases. They are referred to the Club by physicians, dentists, clergymen, teachers, Public Health units, postmasters, private individuals and so forth. Each case, as referred, is assigned to a Rotarian who visits the home and investigates; sees that the child is brought to the Clinic, stands on call when it is being examined and gives his time and assistance in helping to carry out such treatment as is advised. The Rotarian Clinic for Waterloo County is of inestimable benefit to the children of the community. It has become so popular that cases from other counties have been brought in. Following the rule that no child shall be turned away, these from outside are examined and reports sent to Rotarians of their respective districts, to be acted upon as may be found convenient. The nurses doing Public Health work in Waterloo County find the Rotarian Clinic a great boon.

District 5

Hospital for Sick Children, Toronto: Miss Stella Hodge (1927) and Miss Alice Vernon (1926) are on a trip extending through the western states to the coast. Miss Miriam Fryer (1929) is spending her holidays in Winnipeg. Miss Mary Leslie (1925) and Miss Marie Grafton (1928) were in charge of the Heather Club children at Bolton Fresh Air Camp for a month. Miss Alice Baxall is spending some time in New York, and Miss Marie Grafton (1928) has gone abroad. Misses Mabel Dunn, Elizabeth Langman and Marjorie Rosseter relieved at the Hospital for Sick Children for the summer months. Miss Jean Mitchell (1931) has left to spend a few months abroad.

District 6

General Hospital, Belleville: Miss Keitha Sine (1930) is relieving on the staff of the Victorian Order of Nurses during the vacation months. Miss Hilda Collier (1921), Operating Room Supervisor, spent her holidays with the Girl Guides in summer camp. Miss Collier was relieved by Miss Ursula Babcock (1930). Miss Dolly M. Church (1927) has successfully completed a course at the School for Graduate Nurses, McGill University, and has been appointed to the staff of the Shriners' Hospital, Montreal. Miss Effra Cronk (1924), Night Supervisor, has been succeeded in her position by Miss Blanche Cryderman (1931). Miss Bessie Allen (1921) has succeeded Miss A. B. Earle (1926) as Supervisor of the Private Wards.

District 8

Hotel Dieu Hospital, Cornwall: On June 25th, the first graduation exercises of the School for Nurses took place at the Hotel Dieu Hospital when eleven graduates received their diplomas. Touches of decoration were skilfully arranged about the stage with large vases of flowers. Mr. George Brennan was chairman, others on the platform were Rt. Rev. Felix Couturier, Bishop of the Diocese, Rt. Rev. Monsignor Corbet and Dr. C. J. Hamilton. Mr. Brennan on behalf of the Sisters extended a cordial welcome to those who were present and gave a brief outline of the Hospital, which began in 1897. Mr. Brennan showed that the remarkable progress, efficiency and equipment of the Hotel Dieu had gone far beyond the expectations of the early founders. Rt. Rev. Father Corbet, who launched the original initiation of the Hotel Dieu clearly demonstrated the steps by which plans were made to function, financial difficulties were encountered and the generous responses made by the people. Rt. Rev. Felix Couturier based his talk on three outstanding qualifications which tend to the all-round success of those engaged in the nursing profession — compassion, cheerfulness and patience. Dr. C. J. Hamilton also spoke of the efficiency of the work being done in the Hospital.

The diplomas were presented by Rev. Father Couturier to the members of the Graduating Class as follows:—Rev. Sister Daniels, Rev. Sister Cleary, Rev. Sister Wood, Rev. Sister Ignastius, Rev. Sister McMillan, Misses Kathleen Deruchie, Margaret Wood, Evelyn McGillis, Helen Fraser, Lilian Major, and Mary Farrell. Special prizes were presented by Rev. Corbet to the following members of the Class—Misses Wood, McGillis, Deruchie, Major, Fraser and Farrell.

The speakers of the evening were unanimous in extending to Miss Katherine McLellan, Director of Nursing, the highest appreciation for the success of the School. Miss McLellan was presented with two beautiful bouquets of flowers. A lovely bouquet of delphiniums and snap-dragons was sent to the Graduating Class by Miss Lydia Whiting, Superintendent, and Miss Gertrude Gibson, Instructor of Nursing, Cornwall General Hospital. Following the exercises, a reception was held at the Nurses Residence.

District 9

The Graduate Nurses Club of North Bay were entertained at their summer meeting at Mirador, the lovely home of Mrs. Fraser, on the shore of Lake Nipissing, on the afternoon and evening of June 29th. Bridge and bathing were the features of the occasion and refreshments were served on the lawn by the hostess, Mrs. Fraser, assisted by Mrs. J. J. Dennis. The graduating class from Queen Victoria Memorial Hospital were guests of honour at the occasion.

Miss E. Linton, who resigned her position as Supervising Nurse in charge of Victorian Order of Nurses at North Bay, has returned from a trip to the Pacific Coast and assumed her new duties with the Victorian Order at Kirkland Lake, the first of August.

Miss E. G. Stevenson, a 1931 graduate of Public Health Nursing, from the University of Toronto, who has been appointed successor to Miss Linton in North Bay, commenced work in July.

PRINCE EDWARD ISLAND

A large number of nurses attended the annual meeting of the Graduate Nurses Association of Prince Edward Island, held in Summerside. Officers were elected and several items of interest disposed of before dinner was served at the Clifton Hotel.

The first quarterly meeting and annual picnic of the Graduate Nurses Association of Prince Edward Island was held at Cavendish Beach, August 3rd. A large number were present and a very enjoyable afternoon was spent. The next meeting is to be held in the Prince County Hospital, the first Monday in November.

PRINCE EDWARD ISLAND HOSPITAL: Miss B. M. Tweedy, Night Superintendent of the Prince Edward Island Hospital, relieved for Miss Mair, Superintendent, while the latter was on vacation at her home in Georgetown. Miss Mary Lowther was acting Night Superintendent at the Hospital for the summer months. Miss M. E. Loft (1929) has taken up her duties as Public Health nurse in King's County, P.E.I. Miss M. F. MacKenzie (1930) has accepted a position at the Polyclinic, Charlottetown. Miss Florence Platts (1930) leaves shortly for Toronto, where she will take a course in Hospital Management. Miss Reid and Miss Rodgerson, recent graduates of the Prince Edward Island Hospital, who have been ill for a few weeks, are both reported convalescent.

On June 14th, 1931, a son was born to Mr. and Mrs. David Wright (Marion Vickerson, 1923), at Montague, P.E.I.

Miss Elizabeth Compton of New York, spent her holidays with friends in Charlottetown.

QUEBEC

ROYAL VICTORIA HOSPITAL, MONTREAL: Miss Edith Buchanan, B.A. (1931), has left to spend some time in England and Scotland, and later will take post-graduate work at University College, London, England. Miss Clare Preston (1922) is returning to China in the fall to continue mission work. While in Canada she took a post-graduate course at McGill University. Miss Evelyn Eaton (1921), who has been in India for several years, is at home on furlough. Miss Louise Weaver (1926) and Miss Eva Carter (1930) are resigning from the staff of the Royal Victoria Hospital to be married this fall. Miss Kathleen Sanderson (1921) has taken a position with the Greater Vancouver Health League. Miss Louise Keith, B.A. (1930), has been appointed Director of Junior Red Cross for Manitoba.

THE MONTREAL GENERAL HOSPITAL: Miss Olive McKay (1905) has resigned her position as Superintendent of the Miramichi Hospital, Newcastle, N.B. Miss C. Denovan (1920) has resigned her position as Assistant Superintendent, Miramchi Hospital, Newcastle, and has been appointed to the Night Staff of the Montreal General Hospital, succeeding Miss Margaret Willis (1918), who is now Night Superintendent, Shriners' Hospital, Montreal.

Miss Marie Des Barres has resigned from the staff of the Shriners' Hospital, Montreal, and is recuperating from an operation which she underwent in the Montreal General Hospital.

The many friends of Miss Barbara McNaughton will regret to hear of her death on June 13th, 1931, from the effect of burns which she received in the Chungking Hospital, China, where she had been engaged in missionary nursing work since 1909. Miss McNaughton was a graduate of the Montreal General Hospital (1901).

VICTORIAN ORDER OF NURSES

TORONTO: Miss Frances Brown, Regina General Hospital, winner of a Crowe Scholarship for 1930, completed the course in Public Health Nursing at the University of Toronto in June, and is on the summer relief staff of the Toronto Branch of the V.O.N. Miss Wood, also from Saskatchewan, and a graduate of the same course is doing temporary duty with the Toronto Branch. Miss Vera Allen, of Toronto, has returned to duty after a two months vacation in England. While in London, Miss Allen visited Bedford College and made many interesting observations of professional interest.

Correspondence.—Excerpt from a letter received recently by the Editor from a graduate of a Canadian School of Nursing now residing in a foreign country: "When one is far afield as we are here, all the news about our friends is doubly interesting. I don't think that the nurse who collects the news of her Alumnae for 'The Canadian Nurse' ever knows how anxiously it is watched for by those who are not in touch closely with their hospitals."

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

BLAKE—On February 1, 1931, at Hamilton, Ont., to Mr. and Mrs. Blake (Josephine Aussem, St. Joseph's Hospital, Hamilton, 1928), a son.

COPELAND—On July 2, 1931, at Assiniboia, Sask., to Mr. and Mrs. Copeland (Muriel Moffat, Winnipeg General Hospital, 1928), twin girls.

COSTIN—On July 24, 1931, to Mr. and Mrs. George Costin (Mary Glidden, Winnipeg General Hospital, 1928), a son.

CROSS—On July 2, 1931, to Mr. and Mrs. E. C. S. Cross (Ruth Connor, Toronto General Hospital, 1925), a son (Edward Lister Stewart).

CURRIE—Recently, to Mr. and Mrs. Robert Currie (Maude Long, Victoria Public Hospital, Fredericton, 1929), a daughter.

DUNCAN—On July 7, 1931, to Mr. and Mrs. Douglas Duncan (Mary Cameron, Winnipeg General Hospital, 1926), a daughter.

ELDERKIN—Recently, at St. Catharines, to Dr. and Mrs. R. Elderkin (Gladys Miller, St. Catharines General Hospital, 1929), a daughter (Jane Ripley).

FEE—On May 25, 1931, at Winnipeg, to Mr. and Mrs. Donald Fee (Laura Broatch, Winnipeg General Hospital, 1919), a daughter.

FLANK—In July, 1931, at Lafayette, Ind., to Dr. and Mrs. Russel Flack (Frances Ellis, Royal Victoria Hospital, Montreal, 1928), a daughter.

HICKS—On April 19, 1931, at Brantford, Ont., to Dr. and Mrs. Hicks (Miss Irving, St. Joseph's Hospital, Hamilton, 1920), a son.

HOGGE—On June 23, 1931, at Montreal, to Mr. and Mrs. W. K. Hogge (Edna Moore, Montreal General Hospital, 1928), a daughter.

HOLMES—On June 12, 1931, to Mr. and Mrs. M. Holmes (Verna Kingsbury, Winnipeg General Hospital, 1929), a daughter.

JACKSON—On June 24, 1931, at Guelph, Ont., to Mr. and Mrs. Lloyd Jackson (Ariel Reed, Guelph General Hospital, 1929), a daughter.

KEMBAR—On August 1, 1931, at Toronto, to Mr. and Mrs. Arthur K. Kembar (Ruth Young, Toronto General Hospital, 1928), a daughter.

LAWRIE—On December 23, 1930, at Hamilton, Ont., to Dr. and Mrs. Lawrie (Mary Battle, St. Joseph's Hospital, Hamilton, 1928), a son.

LEWIS—In July, 1931, to Mr. and Mrs. Ray Lewis (Margaret Bateman, Toronto General Hospital, 1929), a son.

MacLAREN—On July 31, 1931, at Winnipeg, to Mr. and Mrs. Arthur MacLaren (Kathleen Chamberlain, Hospital for Sick Children, Toronto, 1926), a daughter.

McNAUGHT—On July 18, 1931, to Mr. and Mrs. David McNaught (Edna McNaught, Toronto General Hospital), a son.

MATTHEW—On July 16th, 1931, at Montreal, to Mr. and Mrs. L. E. Matthew (Phyllis Tremaine, Montreal General Hospital, 1927), a daughter.

MORSON—On July 3, 1931, to Mr. and Mrs. Alfred Erroll Morson (Emo Gilmour, Toronto General Hospital, 1928), a daughter.

MURRAY—On June 12, 1931, to Mr. and Mrs. W. G. Murray (Cecile Ray, Winnipeg General Hospital, 1924), a son.

MYSHRALL—Recently, to Mr. and Mrs. Luman Myshrall (Christinia Hunter, Victoria Public Hospital, 1928), a son.

O'DELL—On June 17, 1931, to Mr. and Mrs. O'Dell (Dorothy Snowden, Toronto General Hospital, 1926), a son (stillborn).

PIERCY—On June 21, 1931, to Mr. and Mrs. Fred. Piercy (Eleanor Stark, Toronto General Hospital, 1925), a son.

PIGOTT—On January 18, 1931, at Hamilton, Ont., to Mr. and Mrs. Pigott (Evelyn Jackson, St. Joseph's Hospital, Hamilton, 1927), a daughter.

PUGH—Recently, to Mr. and Mrs. Dawson Pugh (Nora Upton, Victoria Public Hospital, Fredericton, 1922), a son.

ROSEAVER—On May 8, 1931, at Winnipeg, to Mr. and Mrs. A. B. Roseaver (Dorothy Mathias, Winnipeg General Hospital, 1929), a daughter.

THOMPSON—On March 31, 1931, in Buffalo, to Mr. and Mrs. Thompson (Phyllis Tryson, St. Joseph's Hospital, Hamilton, 1926), a daughter.

SIBBITT—On July 31, 1931, at Winnipeg, to Mr. and Mrs. M. A. Sibbitt (Marie Brown, Winnipeg General Hospital, 1917), a daughter.

SINCLAIR—On May 28, 1931, to Mr. and Mrs. J. S. Sinclair (Maude Hodgson, Winnipeg General Hospital, 1926), a daughter.

WARD—On July 28, 1931, at Winnipeg, to Mr. and Mrs. J. F. Ward (Frances McLeod, Winnipeg General Hospital, 1924), a daughter.

WATSON—On July 13, 1931, to Mr. and Mrs. R. Watson, of Halifax, N.S. (Dorothy Hanson, Winnipeg General Hospital, 1927), a daughter.

WEBSTER—On May 17th, 1931, at Windsor, to Mr. and Mrs. Leo. Webster (Ann Penman, St. Catharines General Hospital, 1928), a son.

WELLS—Recently, at Toronto, to Dr. and Mrs. Beecher Wells (Catherine Rudolf, Hospital for Sick Children, Toronto, 1928), a daughter.

MARRIAGES

BEHOO—BARRON—On June 17th, 1931, at Guelph, Ont., Henrietta Ross Barron (Guelph General Hospital, 1925), to George Behoo, of Streetsville, Ont.

CAMPBELL—SCOTT—On May 23, 1931, Ida May Scott (Belleville General Hospital, 1927), to Jay Campbell.

CHEISMAN—DAVIDSON—On July 18th, 1931, in London, Eng., Elizabeth Munro Davidson (Royal Victoria Hospital, Montreal, 1929), to Charles Russel Bailey Cheisman.

CRAMER—DUNLOP—Recently, at Port Colborne, Ont., Dorothy Elizabeth Dunlop (St. Catharines General Hospital, 1930), to Dr. Joseph Cramer, of Woodville, Ont.

CUMMING—GORDON—On July 1, 1931, at Guelph, Ont., Mary Christina Gordon (Guelph General Hospital, 1911), to Edward Graham Cumming, of Elora, Ont.

DAVEY—McKENZIE—On July 18, 1931, Helen E. McKenzie (Belleville General Hospital, 1929), to Wilfred G. Davey.

EVANS—McCONNELL—On May 11, 1931, Ethel McConnell (Victoria Public Hospital, Fredericton, 1924), to David Evans, of Cardigan, N.B.

GILLESPIE—ROWE—On July 11, 1931, Emma K. Rowe (Belleville General Hospital, 1929), to Donald H. Gillespie.

HAYES—DUNNIGAN—On June 2, 1931, at Hamilton, Ont., Mary Dunnigan (St. Joseph's Hospital, Hamilton, 1925), to John Hayes, of Detroit.

HENSTOCK—FOWLER—On August 5, 1931, at St. Catharines, Ont., Ethel Grace Fowler (St. Catharines General Hospital, 1915), to Herbert Henstock, of Paris, Ont.

HINCH—MITCHELL—On June 1st, 1931, at Montreal, Gladys F. Mitchell (Montreal General Hospital, 1925), to F. Hinch.

IRWIN—REECE—On August 5, 1931, at St. Catharines, Ont., Doris M. Reece (St. Catharines General Hospital, 1924), to Andrew E. Irwin.

JOYCE—BOYD—On August 3, 1931, at Winnipeg, Mary Boyd (Winnipeg General Hospital, 1930), to Wilfred Joyce.

McCORDICK—JOHNSON—In July, 1931, at Montreal, Thelma Johnson (Royal Victoria Hospital, Montreal, 1930), to Dr. A. H. McCordick.

MILLER—TUCKER—On July 2, 1931, Myrtle Iona Tucker (Stratford General Hospital), to Lloyd Miller, of Stratford, Ont.

RONNING—JARDINE—On July 1, 1931, at Hamilton, Ont., Nora Jardine (St. Joseph's Hospital, Hamilton, 1924), to Adolf Ronning, of Hamilton.

RUSTIN—BROWN—On March 23, 1931, Margaret Brown (Victoria Public Hospital, Fredericton, 1929), to Edward Rustin, of Providence, R.I.

WHITLEY—IRWIN—Recently, at Toronto, Ida Mae Irwin (Hospital for Sick Children, Toronto, 1931), to Frederick Whitley.

DEATHS

ELDER—On June 15, 1931, at Maryville, Tenn., U.S.A., Mrs. (Dr.) Eugene B. Elder (Margaret Celena Borthwick, Guelph General Hospital, 1896).

FLOYD—On July 26, 1931, at Toronto, Frances Floyd (Riverdale Hospital, Toronto, 1929).

NISBITT—On July 24, 1931, at Detroit, Mich., Helen Nisbitt (St. Catharines General Hospital, 1918).

SHAVER—On July 9, 1931, accidentally killed on Prince of Wales Highway, Ottawa, Ont., Laura Shaver, age 21 years (Ottawa Civic Hospital, 1931).

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HOSPITAL SWEEPSTAKES BILL KILLED BY SENATE

The Hospital Sweepstakes Bill was killed for this session in the Senate, when an amendment giving the bill a six months' hoist was carried by a vote of 34 to 22. Both House leaders voted for the amendment. The Bill, which was introduced by Senator Barnard of Victoria, B.C., would have made it legal for hospitals to conduct sweepstakes with the consent of the Attorney-General of any Province. The Bill has been removed from the order paper, and therefore cannot be considered again unless introduced next session. Strong support for this Bill was forthcoming from British Columbia, where the feeling is that sweepstakes should be permitted as a means of raising money for hospitals.

—"The Canadian Hospital," August, 1931.

THE HISTORY OF THE SCHOOL FOR NURSES, TORONTO GENERAL HOSPITAL

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Meetings held first Thursday every month.

GRADUATE NURSES ASSOCIATION, KITCHENER AND WATERLOO

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A.A., BELLEVILLE GENERAL HOSPITAL

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Regular meeting held first Tuesday in each month at 3.30 p.m. in the Nurses' Residence.

A.A., BRANTFORD GENERAL HOSPITAL

Hon. President, Miss E. Muriel McKee, Superintendent; President, Miss I. Marshall; Vice-President, Miss A. Hardisty; Secretary, Miss H. D. Muir, Brantford General Hospital; Assistant Secretary, Miss F. Batty; Treasurer, Miss L. Gillespie, 14 Abigail Ave., Brantford; Social Convener, Miss M. Meggitt; Flower Committee, Misses P. Cole and F. Stewart; Gift Committee, Mrs. D. A. Morrison, Miss K. Charnley; "The Canadian Nurse" and Press Representative, Miss E. M. Jones; Representative to Local Council of Women, Miss G. V. Westbrook.

A.A., BROCKVILLE GENERAL HOSPITAL

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A.A., HAMILTON GENERAL HOSPITAL

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Regular Meeting—First Thursday of each month.

A.A., OSHAWA GENERAL HOSPITAL

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A.A., ST. LUKE'S HOSPITAL, OTTAWA

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A.A., OTTAWA GENERAL HOSPITAL

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A.A., STRATFORD GENERAL HOSPITAL

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A.A., MEMORIAL HOSPITAL, ST. THOMAS

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A.A., GRANT MACDONALD TRAINING SCHOOL FOR NURSES, TORONTO, ONT.

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Meetings will be held the second Tuesday in each month at 8 p.m. in the Assembly Room, Nurses' Residence, Toronto Western Hospital.

A.A., WOMEN'S COLLEGE HOSPITAL, TORONTO

Hon. President, Mrs. H. M. Bowman; Hon. Vice-President, Miss Harriet Meiklejohn; President, Miss Vera Allen; First Vice-President, Miss Munns; Second Vice-President, Miss Lougheed; Recording Secretary, Miss Bankwitz; Corresponding Secretary, Miss Blair, 64 Delaware St.; Assistant Secretary, Miss Clark, 64 Delaware St.; Treasurer, Miss B. Fraser, 526 Dovercourt Rd.; Representatives to Central Registry, Miss Bankwitz, Miss Kidd; Representative to District No. 5, Miss Clarke; "The Canadian Nurse," Miss E. E. K. Collier.

Meetings at 74 Grenville St., second Monday in each month.

A.A., CONNAUGHT TRAINING SCHOOL FOR NURSES, TORONTO HOSPITAL, WESTON

Hon. President, Miss E. MacP. Dickson, Toronto Hospital, Weston; President, Miss E. Eldridge; Vice-President, Miss A. Atkinson; Secretary, Miss E. L. Barlow, Toronto Hospital, Weston; Treasurer, Miss P. M. Stuttle.

A.A., HOTEL DIEU, WINDSOR, ONTARIO

President, Miss Angela Code, Maple Apts.; First Vice-President, Miss Helen Piper; Second Vice-President, Miss Alice Baillageon; Secretary, Miss Helen Slattery; Treasurer, Miss Evelyn Wolfe; Press Correspondent, Miss Mary A. Finnegan.

A.A., GENERAL HOSPITAL, WOODSTOCK

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Meeting—First Monday of each month, at 9 p.m.

MONTREAL GRADUATE NURSES' ASS'N

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Regular Meeting—First Tuesday of January, April, October and December.

A.A., CHILDREN'S MEM. HOSP., MONTREAL

Hon. President, Miss A. S. Kinder; President, Mrs. F. C. Martin; Vice-President, Miss Alice Adlington; Secretary, Miss M. Flander, Children's Memorial Hospital; Treasurer, Miss H. Easterbrook; Representative to "The Canadian Nurse", Miss Viola Schneider; Sick Nurses' Committee, Miss Ruth Miller, Miss Alexander; Members of Executive Committee, Mrs. Moore, Miss B. Cleary; Social Committee, Misses Gough, Paterson, Bell, Atkinson.

A.A., MONTREAL GENERAL HOSPITAL

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A.A., HOMOEOPATHIC HOSPITAL, MONTREAL

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A.A., ROYAL VICTORIA HOSPITAL, MONTREAL

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A.A., WESTERN HOSPITAL, MONTREAL

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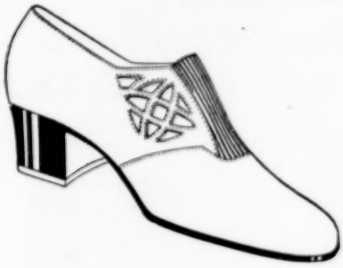

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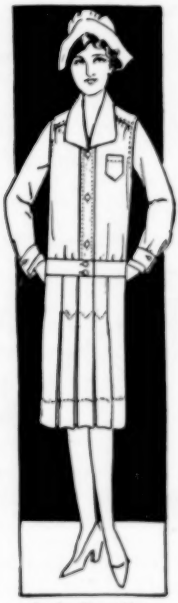

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